# Sex Offender Treatment Program:

# Initial Recidivism Study

**Alaska Department of Corrections**
**Offender Programs**

**Alaska Justice Statistical Analysis Unit**
**Justice Center**
**University of Alaska Anchorage**

**JC 9602.01**

**July 31, 1996**

ERRATA

Reference Pg. 46, paragraph 2 and Pg. 51, Figure 27:
Although the actual number of Native sex offenders who left the program during the Beginning stage is greater during the Langdon period than during the Current period, the percentage of Natives leaving during the Beginning stage is actually greater during the Current period.

*Note (2 Aug 2013)*: This scanned version of the original publication has been annotated on the appropriate pages to reflect the corrections noted above.

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July 31, 1996

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## Acknowledgments

The production of this document was particularly long and labor-intensive. It would not have been possible without the help of a number of people from various agencies, including the University of Alaska Anchorage Justice Center, the Department of Corrections, and the Department of Public Safety.

At the Justice Center, there are several individuals who deserve special recognition for their work: Richard Curtis performed miracles putting all of the odd pieces of the database together, making it one of the most comprehensive and useful in the country. Cassie Atwell performed the main data entry and was assisted by Patricia Peden and Rhonda Horn. Research Associates Nancy Johnson, Samantha Moeglein and Julie Watson assisted in the preliminary SPSS analysis. Tracie Howard did an excellant job in producing the survival analyses and charts. A special acknowledgment is also made of the efforts by Melissa Green, who created all of the fine charts and tables.

At Public Safety, the authors acknowledge the efforts made by Bruce Detloff to provide the APSIN criminal arrest record checks via a special program he created.

At Corrections, the authors acknowledge the special efforts made by Steve Schwartz in managing to make our database "talk to" the OBSCIS and APSIN systems. We additionally want to thank the Wing Counselors at Hiland Mountain Correctional Center for their involvement in searching for often elusive data. Special thanks go to Sgt. Franny Main, who was frequently called upon to assist in the data entry process. Also at DOC, many thanks to Betsy Robson for her careful reading of our initial draft and to Wanda Schloeman for her precise editing of the final.

The authors are hopeful that this is only the beginning of a concerted effort to use research and data analysis as an integral part of providing conscientious and therapeutically-sound programming to sex offenders in the Department's custody.

R. Munafo, 7/31/96

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# Sex Offender Treatment Program:
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## I. Introduction

The Alaska Department of Corrections and the Justice Center at the University of Alaska Anchorage recently completed a study of sex offenders who had been in the treatment program at Hiland Mountain Correctional Center during the period of January 1987 to August 1995. This effort to analyze information about the participants at the Sex Offender Treatment Program was originally begun during Fiscal Year 1993. After a private contractor failed to complete his contractual obligations, the UAA Justice Center was contacted for assistance in completing the project. There have been numerous problems along the way, many of which were inherent in building a database that includes records covering such an extended period of time. The compilation of the recidivism statistics was especially labor-intensive, due to the fact that the three databases utilized in this part of the study (Corrections' OBSCIS system, Public Safety's APSIN system, and the sex offender program database) do not readily "talk to" each other. This resulted in a great deal of manual compilation of data.

This report begins with a summary of the history of sex offender treatment in Alaska, including the current status of the programs offered by the Department as well as a summary of the treatment philosophy followed by all of the Department's Sex Offender Treatment Programs.

In order to best assess treatment efficacy, researchers typically begin by reviewing the work that has gone before them. This document continues with a literature review that includes information initially compiled by students of the UAA Justice Center, with additional information compiled by the authors.

The report then describes the methodology used in completing this study, including a description of the treatment and control groups studied, as well as a discussion of the definition of recidivism used in the study. Data for the treatment group only includes information on offenders who were at the Hiland Mountain Sex Offender Treatment Program, as this is the only program for which comprehensive historical records exist.

Next, the results of the study are presented. Findings reported in this section are divided into three major areas. The first is basic demographic information which describes the offenders and helps us to understand "who" the participants were. The second section tells us something about program variables, i.e. what was "done" in treatment. The third and final area of the results section gives information about re-offense. This tells us something about the effectiveness of the program with respect to how long the offenders "survived" compared to control groups.

Finally, this report closes with a summary of the noteworthy findings and recommendations for further study. Recommendations for further development of the Sex Offender Treatment Programs operated throughout the Department of Corrections are offered which address the common goal of reducing the number of victims of sexual assault.

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# II. Sex Offender Treatment in Alaska

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## II. Sex Offender Treatment in Alaska

### A. History

The sex offender treatment program (SOTP) has been developed, over a number of years, by the Alaska Department of Corrections (DOC), in conjunction with a variety of individual contractors. DOC has attempted to develop the programs along a continuum of care in a number of regions throughout the State.

The first program was opened in 1979 at Lemon Creek Correctional Center (LCCC), Juneau, Alaska. The program was established via a small Law Enforcement Administration Act (L.E.A.A.) grant of approximately $18,000.00 and worked with 10, and later 15 sex offenders, at any given time. The program received L.E.A.A. funds for two years and was then funded by the Department of Corrections for another one and a half years. The program participants were housed in the general population and received individual and group therapy without the benefit of a treatment milieu. The program at LCCC was closed in 1982. It was re-established in 1985 and was revised in 1989 and again in 1992. The program currently houses 24 inmates in a milieu setting and provides Pretreatment and Pre-release services.

The second institutional program was developed in 1981 at Fairbanks Correctional Center (FCC) and housed 32 inmates in a milieu program setting. This program was closed in 1992. The make-up of the FCC population was largely unsentenced felons (60%) and misdemeanants (15%). Thus, when the institution reached population caps there was a natural tendency to transfer program participants rather than short term prisoners or those who would need to be available for court. This created an atmosphere of instability for the program participants and the program itself. The Department followed the recommendations of a special task force and closed the program, transferring continuing program participants to other institutional programs. Community based programs for sex offenders continue in the Fairbanks area.

A third institutional program was established in 1982 at Hiland Mountain Correctional Center (HMCC) in Eagle River just outside of Anchorage. This program currently houses approximately 85 sex offenders in a milieu setting. Seventy of these are involved in intensive treatment programming and 15 are involved in pretreatment programming/screening. The HMCC program is currently the only multi-phase institutional treatment program for sex offenders in Alaska and offers specialized services to the developmentally disabled sex offender as well as to female sex offenders. There are presently four contract therapists, one of whom provides clinical supervision in addition to direct services to inmates. This program uses specially trained correctional officers as wing counselors, who assist the contractors in maintaining an intensive therapeutic environment. There is also a contract plethysmograph technician.

### B. Continuum of Care

For a period of time in the evolution of sex offender treatment programs in the State of Alaska there were three distinct programs operating simultaneously. At their peak these three programs provided for 124 offenders at any given time (80 at HMCC, 32 at FCC and 12 at LCCC). Having programs operating in Juneau, Eagle River and Fairbanks offered the advantage of making treatment available in institutions in the three main regions of the state. Unfortunately, maintaining consistency between programs was an ongoing problem. The programs in the three facilities were not closely linked and offered very diverse programs. There were somewhat different expectations and procedures, causing confusion and frustration for those program participants who, for one reason or another, had to transfer between institutions. DOC hired several consultants in 1991 to evaluate the sex offender programs. One of the recommendations stemming from these evaluations was to create a continuum of services rather than duplicating services in several areas. It was also recommended at this time that DOC adopt the Relapse Prevention model as its primary approach as this model has been shown to be particularly effective in the treatment of sex offenders.

Since this time DOC has developed and implemented the centralized services model. Efforts towards coordination continue as Pretreatment and treatment programs in the institutions and communities strive to provide the Relapse Prevention model in a consistent manner. DOC sponsored professional workshops on Relapse Prevention (RP) in 1991 and 1994 to enhance the knowledge of providers and to encourage consistency of approach. Additionally, in 1992, the DOC established a process to review and approve therapists to provide sex offender treatment consistent with the Department's model. There are currently 39 pretreatment spaces (24 at LCCC and 15 at HMCC) and 70 treatment openings for a total of 109 institutional program beds. It should be noted that funding previously used for additional institutional program spaces has been diverted to enhancing the number of available community treatment spaces.

Community based treatment for sex offenders in Alaska originally was conceptualized as "aftercare" or follow-up counseling for offenders who had participated in the institutional programs. In reality, most offenders in community programs have not received institutional treatment. The reasons for this are several. Many offenders do not receive sufficient sentences to enable them to enter the institutional treatment program. Some sex offenders receive no jail time at all. Others refuse treatment in prison but agree to participate once they are released from prison. During the most recent program review, it was learned that anywhere from 45-90% of the participants in the contracted community programs had had no prior institutional treatment. Contracts for community SOTP's currently exist in Anchorage (30 spaces), Fairbanks (15 spaces), Juneau (15 spaces), Bethel (10 spaces), Kenai (10 spaces) and Ketchikan (10 spaces).

Additionally, there are numerous approved providers throughout the State who do not have a contractual relationship with the Department. Offenders who chose to see an approved provider who is not under contract to the DOC are responsible for their own treatment expenses. Only programs operated by DOC Approved Providers, and which meet the DOC Standards of Care, are recognized by the Alaska Department of Corrections as approved sex offender treatment programs.

## C. Relapse Prevention Model

The operation of a sex offender treatment program can draw from several models and treatment approaches that are currently used in the treatment of sexual aggression. One particular model, the Relapse Prevention (RP) model, has been used for a number of years and has been demonstrated to be effective in the treatment of sexual aggression. This model, adapted by Pithers, Marques, Gibat and Marlatt (1983) from a substance abuse model developed by Marlatt and Gordon (1980), is a cognitive-behavioral approach to treatment. As previously noted, this model was adopted by the Department as part of the move toward a centralized services model.

RP is defined as a maintenance oriented self-control program that teaches sex offenders how to determine if they are entering into high risk to re-offend situations, self-destructive behaviors, their deviant cycle patterns, and a potential re-offense. RP is based on the reality that sex offenders are responsible for their behaviors and can control them. It helps them explore factors which lead up to committing sexual assaults and teaches them a variety of interventions to use in the community as a part of their personal maintenance program. The RP model teaches sex offenders that they must make a commitment to abstain from participating in future deviant sexual behavior. In doing so it teaches them how to cope with those situations which can lead to relapse. The offenders learn new behaviors to substitute for the old and destructive ones they have engaged in previously. Prevention of sexually deviant, criminal, and other abusive and destructive behavior is promoted as the primary goal for all sex offenders who enter treatment.

RP's main purpose is to identify the events and processes that lead up to the deviant behavior and contribute toward relapse (Marlatt, 1985). Relapse Prevention is a program model that combines behavioral management skills with cognitive processes to "intervene" and thereby modify the specific behavior that has been targeted. Sexually deviant behavior is defined as any inappropriate sexual behavior that involves non-consenting partners (this includes partners under the age of 18 years old or individuals judged by the Alaska Court System as being

adult but unable to be responsible for personal decisions), or behaviors that present a danger to the individual or others, and as defined by Alaska Statute. The focus is not to "cure" or remove all temptation, but to develop ways to manage and cope with the ongoing sexual desires, to teach the individual to be responsible for internal and external stressors (Salter, 1988).

## D. Program Descriptions

Depending on an offender's custody status, sentence length and readiness for treatment, programming may be provided in the institutional pretreatment and treatment programs, as well as in community programs. The nature of treatment itself varies according to the offender's readiness for treatment, the nature of the offense and other factors.

**1. The LCCC Sex Offender Pretreatment Program**

An intensive pretreatment program is housed in the Lemon Creek Correctional Center in Juneau. LCCC is a maximum security prison and is therefore able to provide screening and pretreatment services to close and maximum security prisoners. The Pretreatment Program is housed in one of four modular dormitories (mods) and houses 24 men in 12 semi-private rooms. All pretreatment activities are held in the mod or the counselor' s office. The offenders use the same cafeteria as the general population and have access to all other programs, recreational activities and work opportunities that are available to the rest of the population.

There is no minimum time requirement for the Pretreatment Program, although offenders seem to need about six months in order to make any progress in accomplishing the goals of the program. Offenders who do not have enough time left to serve to receive treatment at HMCC can receive pretreatment services at LCCC. The Pretreatment Program evaluates these offenders and determines their amenability to treatment. Offenders who are amenable are oriented to the treatment process in preparation for treatment in the community.

Pretreatment groups are a combination of didactic education and group process. Groups are held twice weekly. Offenders also receive individual treatment on a monthly basis. Offenders undergo psychological testing and their social, family and sexual histories are reviewed in detail. Institutional behavior is evaluated and observations are made of the offenders behavior and attitudes while in program. This results in an assessment of the offender' s amenability to treatment and the establishment of an individualized pretreatment and management plan. Ordinarily, amenability assessments are completed within 90 days. Offenders generally remain in Pretreatment for 12 months or less.

The LCCC Pretreatment Program houses offenders who are on two different tracks. One group of offenders are being evaluated for and oriented to treatment at HMCC. These men meet the necessary time requirements and other eligibility criteria for the institutional treatment program, however, their custody may be so high that they are not eligible for transfer to HMCC. Participation in pretreatment may enable some offenders to gain a custody decrease. The second track of offenders are evaluated for treatment in the community and are assessed for and oriented to this treatment setting. Some offenders are not amenable to treatment in either setting. Offenders who, after receiving pretreatment, continue to accept no responsibility for their offense(s) are an example. A thorough assessment is made of these offenders and recommendations are made regarding management strategies. This assists the field probation officer in the supervision of these high risk offenders.

Progress in pretreatment is monitored by a Pretreatment Team. This is composed of contract staff (therapists) as well as DOC staff (e.g., probation officer, work supervisor, correctional officers and other institutional staff with knowledge of the offender). The Pretreatment Team consults and coordinates with the Clinical Supervisor at HMCC regarding potential transfers to the HMCC program.

**2. THE HMCC Sex Offender Treatment Program**

The SOTP is housed within the Hiland Mountain Correctional Center. HMCC is classified as a medium security facility. The architectural structure of the facility lends itself to the therapeutic community treatment model. Two of the four housing units are designated as sex offender program houses. They contain space for seven 10-man wings for treatment and one 15-bed wing for pretreatment.

The SOTP is available for adult male sex offenders who have been convicted and sentenced for sexual offenses and who have 18 months to 6 years remaining until release or a possible parole date. Sex offenders must meet several other eligibility criteria before being admitted into program. These include a willingness to participate in programming, an ability to benefit from the program, and a willingness to accept responsibility for the offense(s). Specific eligibility requirements are listed in Alaska Department of Corrections *Standards of Care for Sex Offender Treatment Programs* (1994).

The majority of sex offenders within DOC are male. Adjacent to HMCC is the women's facility at Meadow Creek. The two institutions have administratively been one for several years. Female sex offenders housed at Meadow Creek who meet program eligibility requirements may receive sex offender treatment services on an individual basis. These women are not treated in treatment groups with male offenders, as it is not seen as therapeutic to attempt to treat both male and female sex offenders within the same group. There are a number of differences between the two which may impact treatment progress, including differences in the dynamics of the offense, differences in communication styles, and differences in the life experiences of female and male offenders.

The SOTP also works with special needs populations. These include offenders with various cognitive impairments, learning disabilities, physical handicaps and mental illness. These individuals must meet the same general eligibility requirements as other offenders but program components may be altered or augmented to compensate for particular disabilities.

The staffing of the SOTP is a unique blend of both public (DOC Correctional Staff) and private (Contract) treatment providers. Correctional Officers act as wing counselors who maintain wing files on each group member. They also conduct individual counseling sessions with each wing member bi-weekly to monitor compliance with a Treatment Plan and regularly attend the daily group counseling sessions held in each wing. Wing counselors also perform many security functions including operational relief and coverage and other duties as may be assigned. A Clinical Supervisor (Ph.D. psychologist) has responsibility for the overall clinical management of the program. He supervises the contract staff, which includes Individual Wing Therapists and a Behavioral Treatment Technician. Individual Wing Therapists supervise clinical activities of the Wing Counselors and are responsible for the treatment of the 10 men on their wing. Therapists provide individual, group, and family therapy (when appropriate). Therapists also provide a number of educational components including victim clarification, empathy and behavioral self-control, behavioral treatment (in conjunction with the behavioral technician), crisis intervention and staff training. Therapists are responsible for writing a summary of progress in treatment at the time of discharge. The Behavioral Treatment Technician operates the plethysmograph, performing regular assessments and treatment under the supervision of the Clinical Supervisor.

An offender's treatment plan and progress in treatment is monitored by the Treatment Team. The Treatment Team is composed of the offender, the offender's wing representative, the wing counselor, the program director, the institutional probation officer, the clinical supervisor, and the contract therapist. The team may include others who have special knowledge of the offender, e.g., a family member, clergyman, potential employer, a field probation officer, or other institutional staff.

The SOTP consists of the following four program phases:

- Pretreatment: The purpose of this phase is to provide assessment, orientation, education, challenge of offense denial, and clinical management. Unlike the Pretreatment Program at Lemon Creek, the primary function of the HMCC Pretreatment phase is to ready offenders for participation in the institutional treatment program.

- Beginning Treatment: This phase prepares offenders to give and receive feedback, to use self-regulation and social skills, to assume responsibility for the current offense and its impacts upon victims, and, focuses on the most immediate precursors to the sexual offense with the creation of external management strategies.
- Intermediate Treatment: This phase addresses the earliest precursors to the offense and develops the skills for more self management of all risk factors. In the Intermediate phase the focus is on the internalization of skills learned in the preceding phase.
- Advanced Treatment: This phase emphasizes the application and generalization of skills to new situations.

Most sex offenders have a form of personality disorder and have difficulty functioning emotionally and socially. This is independent of IQ, education, socioeconomic status, race and culture. People with personality disorders distort input from the environment and project their own needs and motives onto the world. This results in the learning of maladaptive patterns or solutions to problems. Treatment is most effective when these underlying thinking patterns and misperceptions are directly targeted for change. Personality disordered people require specialized treatment approaches. These approaches increase access to the personality structure and improve the accuracy of assessment as well as the effectiveness of treatment and management strategies. Traditional mental health concepts and strategies will not work unless they are modified and adapted for work with the personality of the sex offender.

The Hiland Mountain Program has integrated both treatment and management within the Relapse Prevention model. The RP model provides for both internal (self directed) and external (Safety Net, Approved Provider, P.O., V.P.S.O.) approaches to the management of assaultive behaviors. As offenders progress further in treatment, they are expected to perform more self management strategies, but management by others is needed as a backup if they fail. Self management includes coping self talk, immediate coping responses for stopping or avoiding any risk factors, and proactive behaviors, which lead towards responsible, long-term life directions.

The Relapse Prevention Plan as it is used at the Hiland Mountain SOTP is a two-step process. The first step, constructed in the Beginning phase, addresses the most immediate precursors to the sexual offense; the second step, assembled in the Intermediate phase, adds the earliest precursors to the offense. The first step RP is similar to Relapse Prevention Plans which have been developed in Canada and the U.S. The second step RP is a Hiland development which incorporates an understanding of the personality disorder. With the exclusion of Pretreatment, each Treatment stage is a minimum of six months and may take 12 months or more. Duration in treatment depends upon the offender's individual resources, problem areas, skills, motivation and length of sentence.

The sex offender population is diverse, therefore, there are different levels of outcome. The HMCC SOTP is not designed with the expectation that every sex offender will complete all stages of treatment. Some offenders may leave the program without completing all stages of treatment, but have gained some benefit. These offenders may lack the ability or the time to go further in the Program. Some offenders will be Sentence Complete, exiting the Program from the Beginning, Intermediate, or Advanced Stage and returning to the community. Others will gain full benefit by completing all stages of treatment, be Residential Program Complete, leave the SOTP, and remain incarcerated until release from prison. Each stage of treatment has a corresponding Relapse Prevention Plan. All levels of outcome will be eligible for follow-up with community programs.

Upon discharge all sex offenders, irrespective of the reason for discharge or their stage of treatment upon release, have a Relapse Prevention Plan. The RP for those who leave against treatment team advice, or for those who are removed by a treatment team, emphasize external management over self-management. Additionally, sex offenders leaving Hiland Mountain with partial or complete program benefit begin to establish a Safety Net while they are still incarcerated, or shortly after release (see discussion of Safety Net on p. 7).

The treatment program at HMCC is an extremely intense and complex process. The treatment plans are highly individualized based upon in-depth assessment and observation of the program participants. Close observation by a

multitude of staff leads to an in-depth and more thorough picture of each particular offender. This allows not only for very specific treatment but also for a more thorough assessment of risk as well as the development of appropriate management strategies. This information is made available to field probation officers and community treatment personnel when offenders are released from prison. This allows for the continuation of appropriate treatment and management strategies which can help reduce the risk of re-offense.

### 3. Community Based Treatment Programs

Community based treatment for sex offenders is provided in several areas of the State. There are a total of 90 community treatment spaces. Currently there are 30 spaces available for community based treatment in Anchorage, 20 in Fairbanks, 10 in Juneau and 10 each in Kenai, Ketchikan and Bethel. Efforts are currently underway to establish community programs in other areas of the state. The number of community treatment spaces has more than doubled since 1992. The community programs are provided through contracts with private therapists approved by the Department. The Department is committed to community treatment and management programs for sex offenders and continues to strive for the development of these programs, as a means of enhancing public safety.

The methods and goals of community treatment are the same as those of the institutional programs. The institutional programs differ in intensity, however, in that they provide pretreatment and treatment within the context of a treatment milieu. This is much more intense than treatment provided in the community, with the offender's behaviors closely monitored and evaluated continually. Interventions can be effected on an ongoing basis. Community treatment would not be able to duplicate the intensity of the institutional milieu.

In 1994, the Alaska Department of Corrections began to develop a Safety-Net program for use in the community. This included development of a training manual, using a grant obtained from the National Institute of Corrections. The manual is used in training people close to the offender to recognize and report pre-relapse signs. This is an attempt to create a structure around the offender similar to that which is provided by the institutional treatment milieu.

Many contractors have begun to use the Safety Net program, especially in smaller, more isolated communities. Although progress is being made, the program is not yet fully integrated into the system. Statewide Standards describe the Safety-Net as a small group of "natural-helpers" who may be in a position to observe the day to day behaviors of the offender in the community. These individuals are trained to recognize pre-relapse signs and to share such signs with staff who work with the offender. This is a means of gaining community support in monitoring and supervising an offender while enhancing public safety. The Safety-Net may serve to reduce public fears by educating people about real versus perceived threats. It may help in providing a sense of empowerment, by teaching those closest to the offender about the signs of pre-relapse behavior and by providing a means of using these observations to improve supervision.

DOC attempts to maintain a consistency of approach not only between institutional programs but also between institutional and community programs. The adoption of the Relapse Prevention Model of treatment has helped to standardize treatment between programs and program sites. The chronology of events significant to the development of sex offender treatment in Alaska are shown in the chart that follows this section of the report.

# Sex Offender Treatment in Alaska

## Significant events

| | |
|---|---|
| 1979 | A pilot sex offender program opens at Lemon Creek Correctional Center |
| 1980 | Alaska initiates presumptive sentencing for Class A, B and C felonies (2nd offense) |
| 1981 | An institutional sex offender treatment program is established at Fairbanks Correctional Center |
| | A community aftercare program is established in Fairbanks |
| 1982 | The Lemon Creek program closes |
| | A pilot program is established at Hiland Mountain Correctional Center |
| | Alaska moves Class A felonies to Unclassified status and initiates presumptive sentencing for a first offense of Sexual Assault and Sexual Assault of a Minor |
| 1984 | A community aftercare program is established in Anchroage |
| | The HMCC SOTP expands |
| 1985 | Plethysmograph assessment and behavioral treatment begin at HMCC |
| | The Lemon Creek program reopens |
| | A community aftercare program is established in Juneau |
| 1986 | Social skills established at Hiland Mountain |
| | Pre-program (pre-treatment) wing is established at Hiland Mountain |
| 1989 | LCCC SOTP is revised |
| 1990 | DOC sponsors statewide training for probation officers |
| 1991 | DOC hires national experts to evaluate Alaska's sex offenders programs |
| | DOC sponsors training in Relapse Prevention for treatment providers |
| 1992 | The LCCC SOTP is reorganized into a pre-treatment program |
| | The Fairbanks institutional program is closed |
| | Community treatment openings in Fairbanks are increased |
| | A community treatment program is established in Ketchikan |
| | An Approved Provider process is established and DOC begins contracting with individual approved providers rather than agencies |
| 1993 | A community treatment program is established in Kenai |
| 1994 | DOC sponsors a training workshop for treatment providers |
| | A Safety Net Training Manual is written |
| 1995 | A community treatment program is established in Bethel |

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# III. Literature Review

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# III. Literature Review

All correctional program evaluations, and particularly evaluations of sex offender treatment programs, are faced with a number of obstacles. The evaluation of a program usually begins by asking such questions as "Does it work?" or "Is it cost effective?" and may even include something specific such as "Does it meet our criteria for Goal A?" When we are asked if a program works, we need to know the definition of "works," and when we are asked if it is cost effective we may need to ask "compared to what?" Thus, the initial questions generate a host of additional questions and answers that must also be addressed, considered, and then decided upon.

The literature review begins with an etiology of sexual offending and is followed by sections which reflect the initial questions posed about factors related to studying recidivism, including: the different working definitions of recidivism that are used in the literature; the differences in recidivism between sex offenders who have attended a treatment program versus those not treated; the optimal levels or types of treatment cited in the literature; and other factors which possibly affect recidivism.

A literature review concerning recidivism reflects only current thinking and previous research. This is an area in which research continues and theory is developing.

## A. An Etiology of Sexual Offending

Appropriate assessment, treatment and management of the sex offender should match the nature, the scope and the depth of the problem. A more accurate understanding of the sex offender would increase the efficiency, the focus and the effectiveness of sex offender treatment, resulting in more accurate predictions of recidivism. It is important to recognize that sex offenses are not isolated behaviors but are the result of many separate factors coming together. Sex offenses are not mistakes or accidents which occur in a moment of excessive impulse. Sexual offenses do not have one cause, for example, early traumatic experiences, parental abuse, parental negligence, low self-esteem, prior sexual victimization, a stressful circumstance, excess sexual hormones, an unusual temptation, or substance abuse. These are popular attempts to seek answers. Simple explanations promise understanding but end up minimizing and excusing the behavior. They oversimplify the scope and the depth of the problem. They do not assure the victim whose basic assumptions about life have been shattered and asks, "Why?" Treatments based upon these assumptions are superficial, waste money, mislead the public trust, and do not help the victim of sexual assault. Substance abuse, for example, will disinhibit prior predispositions to commit sexual assault, but substance abuse is not the cause of sexual assault nor can it be allowed to excuse subsequent arrestable behaviors. For some offenders substance abuse may be one of many risk factors which are near the end of a long chain of events.

Most sex offenders have a form of personality disorder. People with personality disorders have difficulty with empathy for themselves or others (Beck, Freeman and Associates, 1990; Hare, 1993; Shapiro, 1981; Yochelson and Samenow, 1976, 1977, 1985). These individuals think in a different way, having many "thinking errors" and deficits in the cognitive processing of social information (Atrops, 1996). They have difficulty processing emotions and making social judgments (Goleman, 1995). Empathy is the prerequisite social judgment skill which makes it possible to develop respect, consideration, common sense, conscience, and principle. The subtlest social judgments are made in intimate social relationships.

Without empathy for others there is a systematic and growing imbalance, contributing to an accumulative series of false solutions and growing negative consequences over the course of a lifetime. The offender will seek to gain increasing control over his external circumstances in a way which will increase the likelihood of his having more positive than negative experiences. These attempts at mastery turn into dominance, alienating others. Problems are not solved, but are postponed or given to others. Solutions are not solutions but illusions which postpone the inevitable. Short-term "fixes" are not long-term correctives for achieving responsible goals. When short-term fixes don't work, the offender goes to even greater extremes to try to maintain balance, however inevitably maintains the imbalance. The net impact contributes to a spreading ripple effect with enormous emotional and

social costs with wide-ranging public, clinical, scientific, moral, theological, legislative, legal and economic concerns.

Sex offenders eventually seek control through direct aggression or through indirect sexual aggression. Direct aggression is overt and easily observable. It is more easily understood as the use of physical force to kidnap and subdue a woman in a rape.

Indirect aggression is covert. It is more often used by professionals who perform rapes on women and by those who sexually assault minors, e.g., same sex pedophiles, opposite sex pedophiles, and incest parents. The indirect aggressor lives a double life, working hard to present a "good guy" image while sexually assaulting others. He tries to get his young victims to share his one-sided thinking. He takes from his victims. He turns his victims against themselves, leaving them without a sense of self or with a fragmented and confused self.

The indirect form of sexual aggression is much harder for lay persons to observe and to understand. This form of aggression includes parallel control strategies as are used by direct aggressors. The pedophile is able to mask, disguise and manipulate victims over longer time spans. The pedophile will attempt to have his whole family, his circle of friends, his coworkers, counselors, institutions, and the court join him in his "incest." The sexual aggressor who uses indirect control is no less aggressive than those who use direct control over a victim.

Neil Malamuth and his associates (Malamuth, Sockloskie, Koss, and Tanaka, 1991; Malamuth, Linz, Heavey, Barnes, and Acker, 1995) propose the "Confluence Model of Sexual Aggression," noting that sexual aggressors against women are characterized by the convergence of several key factors which may be organized into two major pathways. The first major pathway includes juvenile delinquency plus impersonal promiscuous sex; the second major pathway includes attitudes supporting violence against women and hostile masculinity, namely, a general proneness to hostility. Ray Knight and Robert Prentky in Bridgewater, MA have replicated Malamuth's work, reviewing the histories of men who have raped women. These findings were presented at the Fourteenth Annual Research and Treatment Conference of The Association for the Treatment of Sexual Abusers (Prentky, Knight & Malamuth, 1995). Recent unpublished research by Malamuth and associates have shown that men who are more self-oriented rather than other-oriented will be at much higher risk for sexual aggression against women when both pathways are present. This self-orientation included a lack of empathy which was part of a much broader personality dimension.

## B. Recidivism Definitions

Previous study of sex offender recidivism generally has not portrayed the sex offender as a serious recidivist. Sturrup (1968) wrote that "very few sex offenders recidivate with a new sexual crime" (p. 9). However, more recent research on sex offender recidivism provides a basis for questioning the accuracy of this impression. Many of the more recent studies reviewed concluded that much of the confusion in research literature can be attributed to differences in measuring the recidivism of a sex offender. It is important to keep in mind that early researchers thought that all sex offenders were alike and did not have a clear picture of the differences that exist between them. Sex offenders are a heterogeneous group, with reoffense rates ranging from low estimates for incest offenders to high rates for pedophiles who prefer pre-pubescent males and exhibitionists.

The evaluation of the effectiveness of treating sex offenders is ultimately based upon whether or not an offender repeats his past sexual assault in a future sexual reoffense. Attempting to measure this new offense(s) involves consideration of time period and the actual event used in the definition. With these two factors in mind, it is not unusual to see that researchers have defined "recidivism" in different ways:

- An accusation or admission of a deviant sexual contact, once treatment had begun, whether or not there was an arrest (Berlin & Meinecke, 1981).

- A recommission of the same type of offense, even if the offender is not convicted for it; recommission of any sex offense, even if different from the original one; and recommission of any criminal offense, even if it is not a sex offense (Furby, Weinrott, & Blackshaw, 1989, p. 8).

- A rearrest for a sexual offense (Marshall, Jones, Ward, Johnston & Barbaree, 1991; Romero & Williams, 1983).

- A conviction for a sexual offense during a specified time period (Furby, et al., 1989). According to the authors, this was the most widely used definition.

There are some concerns about the use of arrest and conviction records to measure the actual occurrence of a new sexual assault. These include the fact that many victims do not report all counts of victimization. Additionally, many sex offenders have admitted to committing two to five times as many sex crimes for which they were not arrested, indicating that arrest and conviction records may underestimate recidivism. Arrest and conviction records may not be the most reliable measure of reoffense (Hall & Proctor, 1987; Weinrott & Saylor, 1991; Groth, Longo & McFadin, 1982).

Other issues may also need to be considered. There is a difference in sex and non-sex reoffense rates based on type of sexual offense. Also, an appropriate recidivism time period for each type of sexual offense is needed. The wide variation in reported time periods for evaluation makes comparison between types of sexual offenses and other studies nearly impossible. Finally, long-term follow-up is crucial in sex offender research, given the low rate at which the offenses of sex offenders are detected and prosecuted. Some types of sex offenders have crime free periods (Romero & Williams, 1985).

## C. Research Designs in Recidivism Studies

Song and Lieb (1994) note that while some studies have shown that particular treatment programs are associated with lower recidivism rates in certain types of sex offenders, there is a lack of solid scientific evidence from controlled experimental studies that clearly demonstrate that treatment programs reduce sex offender recidivism. An experimental design in which the subjects are randomly assigned to a treatment or control group is the ideal method for treatment evaluation, in that it controls for all factors which may influence recidivism (such as age or type of offense). Because random assignment is usually not possible, and may be ethically questionable, a quasi-experimental design may be used in which a group of treated offenders is compared to a group of non-treated offenders who are similar in demographic and offending characteristics. Marques, Day, Nelson and West (1994) note that only a comparison group can determine the actual effectiveness of a treatment program in reducing recidivism.

The only controlled study of recidivism (Marques et al., 1994) in an ongoing program is California's Relapse Prevention Program at Atascadero State Hospital. Subjects were rapists and pedophiles. The study, begun in 1985, employs a research design that includes three groups: a treatment group, a volunteer control group (those who volunteered for but did not receive treatment) and a nonvolunteer control group (those who refused the opportunity for treatment). Treatment subjects were less likely to commit new sex offenses than were nonvolunteers and it is noted that this is a significant result. The researchers have also reported that early treatment dropouts were at higher risk for new sex crimes than those who completed a year or more of treatment and that treated child molesters were less likely to commit other violent crimes than were molesters in the volunteer control group. Marques, et al. (1994) note, however, that although the results are promising, a consistent picture of treatment effects has not yet emerged. Despite this, the study results highlight the importance of including appropriate comparison groups when addressing the issue of treatment effects, as well as the need to control for a number of other factors, such as attrition from both treatment and methodological standpoints, examining sex and other violent offenses separately as outcome variables, employing adequate statistical tests, and analyzing data from the standpoint of time at risk for reoffense.

## D. Differences in Recidivism between Treated and Untreated Sex Offenders

The effectiveness of treatment is tied to certain characteristics of the offender, as well as to the type of treatment offered. Not all offenders are amenable to treatment, and not all treatments are effective with sex offenders. McGrath (1991, p. 320) identificd three factors necessary for effective treatment with sex offenders: a) the offender must acknowledge he committed the offense and accept responsibility for his behavior; b) the offender must consider his sexual offending a problem that he wants to stop; and, c) the offender must be willing to enter into and fully participate in the treatment.

It is unclear in most studies if, and how, amenability was assessed. Studies which pool many different forms of treatment of sex offenders (Furby, et al., 1989) showed less discrimination between treated and untreated sex offenders. Pithers and Cumming (1989), who worked with Relapse Prevention Planning, observed that outcome studies of treated sex offenders should evaluate specialized forms of treatment. Some of the treatments reported on by Furby, et al. (1989) were not cognitive-behavioral models.

A "meta-analysis" by Hall (1995) was performed on 12 studies of treatment with 1,313 sex offenders. Hall examined programs with three basic treatment approaches: behavioral, cognitive-behavioral, and hormonal. The summary recidivism rate was 19% for treated offenders versus 27% for untreated offenders. Cognitive behavioral and hormonal treatments were found to be more effective than behavioral treatments alone, but were not significantly different from each other. The longer the follow-up period, the more pronounced the treatment effect, with studies having follow-up periods longer than five years showing a greater treatment effect than studies with follow-up periods of less than five years.

## E. Differences in Recidivism between Types of Treated Sex Offenders

Sex Offenders are a heterogeneous group. Reoffense rates are lower for incest offenders and higher for pedophiles who prefer prepubescent boys and exhibitionists.

Lang, Pugh and Langevin (1988) as cited by Becker and Hunter (1992:83) reported on the response of incest offenders and opposite sex pedophiles to group therapy which included a wide variety of techniques. About 7% incest offenders reoffended while 18 percent of pedophiles reoffended.

Marshall and Barbaree (1988) as cited in Becker and Hunter (1992:87) looked at recidivism rates of treated and untreated pedophile offenders, who were categorized as incestual relations, non-familial female children and non-familial male children. Treated pedophiles had 13.2 percent recidivism; while 34.5 percent of non-treated pedophiles recidivated.

Marshall, et al. (1991) discussed a cognitive behavioral program in Canada which based recidvism on official records. Inmates near the end of their sentence volunteered for the program. Results showed recidivism rates of 11% for treated and 35% for untreated inmates. The program appeared to have better results with pedophiles than rapists.

Sturgeon and Taylor (1980) examined the recidivism status of all sex offenders from all treatment programs from California's Atascadero State Hospital released in 1973. The offenders were followed from 1973-1978. Rapists were more likely to reoffend in the first year after release, while pedophiles recidivated 2-3 years after discharge. They found that 18% of pedophiles reoffended, while 26% of rapists reoffended.

Pithers and Cumming (1989) evaluated the effectiveness of Relapse Prevention Planning in 167 offenders released from the Vermont Treatment Program for Sexual Aggressors with 3% of pedophiles and 15% of rapists reoffending after 6 years in the community. It may take longer for a pedophile to reoffend since the pedophile proceeds through a series of stages to "groom" the victim. This may make them more accessible to Relapse Prevention Planning.

Prentky and Knight (1991) claim that recidivism rates are so high among rapists because they have not been properly assessed. They believe treatments are less effective with rapists because they are treated as a homogenous group. These authors feel rapists should be assessed to determine specific typology so that a more effective treatment can be administered.

## F. Differences in Recidivism between Types of Treatment

Ideas regarding the treatment of sex offenders have moved from a view of punishment as the only response to an act viewed solely as criminal towards the idea of "curing" offenders of their mental illness (Marques, Day, Nelson, Miner & West, 1991). The move towards "curing" mental illnesses of sex offenders tapered off during the late 1970s when results from psychotherapy programs were not showing the promise once hoped. Many suggested that these early types of therapy did not reduce the amount of recidivism (Dix, 1976; Frisbie, 1969 as cited in Marques, et al., 1991). Workers in the field have abandoned the mental illness view of sexual offending and have reconceptualized the treatment approach. Methods of slowing the rate of recidivism have emerged from this reconceptualization.

The success rates of the early programs were measured by asking the treated offenders whether or not they felt like committing any more crimes. Studies of the early treatment plans focused on the immediate outcome and recidivism rates for the long run were virtually ignored. The experimental groups were so small that generalizations were not possible (Murray, 1987; Romero & Williams, 1983; Berlin & Meineck, 1981).

Insight-oriented psychotherapy was the original treatment used for sex offenders. This type of psychotherapy is a process involving introspection by the sex offender. Many psychotherapeutic approaches assume that deviant sexual behavior is the result of trauma in the offender's past. While it is true that trauma can play a role in the etiology of sexual deviancy, these approaches often result in the offender blaming others for his problem rather than taking personal responsibility for his criminal acts. Evaluating the results of insight-oriented psychotherapy is complicated and there are no common standards of measurement (Becker & Hunter, 1992). Many have reported disappointing results when psychoanalysis or insight-oriented psychotherapy is the sole treatment, especially in cases where deviant sexual arousal is dominant. Additionally, insight-oriented psychotherapy is not always conducive to the prison setting, in that it requires the offender to be fairly intelligent, have a "capacity for abstract thinking and self-observation,...a sense of distress and motivation for change, and an ability to form a working relationship with a therapist... that may extend a long period of time and that may involve considerable emotional discomfort and frustration" (Baker, quoting Groth, 1979).

Penile plethysmography (Laws, 1989) in which a sex offender's penile arousal to auditory or visual stimuli were used to assess and treat deviant sexual arousal have been in use since about 1966 and continue to be components in an effective sex offender treatment program. Behavior modification has been used to apply learning theory, e.g. classical conditioning, operant conditioning, to decrease undesirable behavior and to replace it with socially approved responses. Few programs use behavior therapy as a sole therapeutic strategy. Hall (1995) suggested that behavioral treatment alone is not as effective as cognitive-behavioral therapy or hormone therapy.

Organic treatments appear to be the most controversial. These treatments manipulate hormone levels in order to alter the offender's libido. Research indicates that the level of the male hormone testosterone can affect sexual aggressiveness. Reduction of the hormone can be accomplished by surgery or drug therapy. Surgery, whether castration or psychosurgery are typically opposed as being overly invasive and possibly unethical techniques. Medication therapy includes the use of estrogens administered orally or by implantation to curb sexual desire (Murray, 1987). Drug therapy can produce negative side effects, such as weight gain, headaches, insomnia, fatigue, depression. Proper duration for treatment is not known due to lack of long term studies (Murray, 1987).

Some programs surveyed by Sapp and Vaughn (1991) used Depo-Provera, while others used androgens (CPA, or Cytoproterone Acetate). The courts have ruled that offenders cannot be forced to use the drug, as it could be considered "cruel and unusual punishment" (p. 22). However, this drug treatment is gaining increased judicial acceptance and may become an important addition to the treatment of certain sex offenders. Depo-Provera poses

few legal and ethical issues when given to fully informed individuals on a voluntary basis (Peters, 1993: 327). While medication therapy may have a role in the treatment arsenal, it needs to be incorporated and integrated into a larger clinical framework.

Cognitive-behavioral approaches which incorporate Relapse Prevention strategies currently appear to have the greatest acceptance by sex offender treatment programs in the U.S. and Canada (Laws, 1989). Antonowicz and Valliant (1992) maintain that "cognitive-behavioral" treatment models hold the most promise for treatment of sex offenders. Programs have become multi-dimensional and target deviant sexual arousal patterns and cognitive distortions as change agents. The promise of these types of programs is that offenders are learning skills to recognize the chain of events and specific risk factors that have led up to their offenses. This method of treatment allows the offenders to interrupt the chain of events in order to avoid reoffense (Marques, et al., 1991).

Post-1980s treatment has been overwhelmed with the need to measure and show success rates in changing re-offense patterns of sex offenders. From this foundation many treatment models begin with the suggestion of follow-up periods of longer than the standard three-to-five years. Relapse prevention succeeds by making the offender aware of the steps which led them to the problem in the first place (Pithers, Kashima, Cumming, Beal & Buell, 1988). The use of RP techniques helps the offender focus on the big picture and not the immediate gratification gained from committing a sexual act. This type of program also prepares the offender for these relapses by showing them how to avoid problem situations.

Pithers, et al. (1988) stressed that treatment does not end with formal therapy-maintenance is forever: "The client who has adequately learned the RP philosophy will continue his own therapy everyday for life." The effectiveness of RP is not clear because of problems of measurement after treatment. Short-term follow-up studies indicate that the treatment works well and should be studied further by following patients in the program over a period of more than three years and even beyond the ten years suggested.

## G. Differences in Recidivism between Court-referred versus Voluntary Treatment

Although it seems likely that involuntary, court-referred sex offenders would be less optimum candidates for treatment than those volunteering for treatment, little documentation has been published on this assumption.

Maletzky (1980) addressed the difference in outcome and compliance between self-referred and court-referred patients. This study consisted of 100 male patients divided into four categories: self-referred and court-referred homosexual pedophiles, and self-referred and court-referred exhibitionists. There were no significant differences in court-referred and self-referred compliance and outcomes.

Alexander (1993) performed a "meta-analysis" on 17 studies with 1470 subjects. Those receiving mandatory treatment had a 10.5 percent recidivism rate. A "meta-analysis" of 29 studies with 2,296 subjects had a 12.4 percent recidivism rate. Since the rate was slightly lower for mandatory treatment, the author suggests that legislating treatment would probably be beneficial.

## H. Survival Analysis

After reviewing the recidivism literature, several generalizations can be made: first, there is no consistently used definition of recidivism. Second, there is a difference in sex and non-sex reoffense rates based on type of sex offense. Third, because victims don't report all counts of victimization, a more accurate form of data collection than just arrest and conviction records is needed. And lastly, an appropriate recidivism time period for each type of sex offense is needed. The wide variation in reported time periods for evaluation makes comparison nearly impossible.

This latter point raises the possibility that an alternative to the fixed recidivism window may be needed to capture the complex relationship between treatment and recidivism. A survival analysis of sex offender treatment data would address the question: "Does treatment extend the time between release and reoffense?" (Kalbfleisch, 1980;

Lawless, 1982; Miller, 1981). A survival analysis avoids the overly simplistic recidivist/nonrecidivist dichotomy and provides a method for evaluating treatment effectiveness independent of a fixed, and perhaps artificial, follow-up time period. This method has the advantage of presenting data patterns over time rather than at a single point in time as is typically seen in conventional statistical analysis. A further advantage is that the researcher can address all subjects in a study, regardless of their individual "time at risk" , and also allows the inclusion of subjects that have been lost to attrition. (Howard, 1996).

## I. Summary

The concept of recidivism is extremely complex, varying not only by definition of the reoffense event but also tied to the time period of the follow-up, the type of offender, and the type and length of program employed. Every program discussed here has had failures, and it is unrealistic to look for total success from any program. However, the definition of "does it work?" is tied to this ratio of success and failure. Based on the literature reviewed here, the general consensus seems to be that Relapse Prevention approaches hold the most promise for reducing reoffense rate among sex offenders. Several other approaches may enhance the RP framework. Treatments that are matched to the specific needs of the offender are likely to be the most effective.

Evaluations of recidivism need to define the outcome measures used along with the sources of possible unreliability. Survival analysis appears to be the statistical method of choice when analyzing reoffense data.

Incarceration alone is not likely to be an adequate intervention for preventing new sexual assaults. "Incarceration is an externally imposed stoppage that does not require from the offender any motivation for voluntary commitment to change the offense patterns." "The offender can maintain attachment to the offense pattern through fantasy." "Depending on the nature of the offense pattern..., it is conceivable that the offender could continue actively engaging in some semblance of the offense pattern while incarcerated" (George & Marlatt, 1989, p. 17).

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# IV. Methodology

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# IV. Methodology

In experimental research, groups that receive treatment are compared to other groups, called control groups, that are similar in all respects but do not receive the treatment intervention. In this way there is a reference for any changes that appear in the treatment group members. The scientific ideal in a research project is to select participants randomly and assign them to the various treatment and control groups. The reasoning is that if changes in the groups are due to unknown variables these changes will appear at random in all groups and cancel each other out. Any resulting differences that appear in the treatment group are then assumed to be the result of the treatment itself rather than the result of unanticipated causes. In the real world this is not typically possible because of the ethical considerations that arise when one refuses treatment to individuals who are in need and willing to participate. For this reason there are few controlled experiments in clinical field research. Marques', et al. (1991, 1994) study of sex offenders in the California system is a notable exception.

Sometimes circumstances are such that control groups are naturally created in field research projects. When this happens the participants in the control and treatment groups are not usually matched in all respects. Nevertheless, some comparisons are possible and the researchers can have more confidence, although not perfect confidence, that results are in fact due to the treatment applied rather than due to some serendipitous effect.

The data from treated offenders in the present study was compared with data from sex offenders and non-sex offenders in several other comparison groups. This allows us to make some conclusions about whether the results are likely to be due to treatment efforts or some other random and unknown factors. While the comparison groups are not ideal, their inclusion allows us to have more confidence in our conclusions.

## A. Groups Studied

Data has been collected on 685 convicted offenders, who are divided into the following groups:

- Sex Offender Treatment Group: 411 male sex offenders who received some level of treatment in the Hiland Mountain SOTP between January 1987 and August 1995. The amount of treatment varied considerably between individuals because of differences in length of sentence and speed with which progress was made by individuals in the program, however, all 411 had some exposure to treatment.

- Motivated Sex Offender Control Group: 74 male sex offenders who requested treatment but did not receive treatment due to an insufficient sentence or the lack of an available treatment bed. This group of men was considered a "motivated" control group as they were willing to accept treatment but, through no fault of their own, this was not available. These men were requesting treatment during the Langdon and Transition period (see discussion below).

- Unmotivated Sex Offender Control Group: 100 male sex offenders randomly selected from the DOC OBSCIS system who did not seek or request treatment. These are considered to be an "unmotivated" control group as they refused treatment, at least while in prison. Closer examination showed that some of the offenders randomly selected were already members of the treatment group, so that only 86 offenders were maintained in this group once the data was corrected.

- Non-Sex Offender Control Group: 100 male non-sex offenders who were randomly selected from the OBSCIS database to provide some comparison between sex offenders and the broader criminal population.

It is important to note that, although these groups were not intentionally matched on demographic variables, a study conducted by Howard (1995) compared a sample of 358 of the offenders on several demographic variables. In Howard's study, 73 of the motivated control subjects were compared to 285 of the treatment group subjects. The variables studied included age, race, marital status, number of children, type of offense, sentence received, veteran status, substance abuse, education and work history background. Results indicated no significant

differences between the groups on any of these variables. We can, therefore, have some confidence that subjects in these two groups were at least roughly equivalent. Figure 1 shows the percentages of offenders in each of the groups.

## B. Groups Not Studied

It is important to point out that the current research did not study all sex offenders who ever received treatment services from DOC. Not all sex offenders ever treated at Hiland Mountain have been included in the study, due to the fact that there is little or no data available on offenders in the program prior to 1985. Additionally, over the years, there have been a number of sex offenders who were treated at sites other than HMCC. In the past, many sex offenders have also been exposed to institutional treatment and pre-treatment at Lemon Creek and Fairbanks Correctional Centers. Additionally, a large number of offenders have received treatment in the various community settings throughout the State. Some of these received community treatment as aftercare or continuing care following some level of treatment at one of the institutional sites. Others received their first exposure to treatment in the community. The data available on these individuals is often very limited. It would be time consuming and expensive to attempt to enter this historical data in the database. It is indeed questionable how much historical data even exists. There is a plan for data to be entered from the LCCC Pre-Treatment Program in the near future. This will allow DOC to evaluate the effectiveness of the pre-treatment component. It would be desirable to also enter data from the Community Programs, however, this may be difficult due to the resources which would be necessary.

## C. Time Periods

The treatment program at HMCC has evolved over time. While this evolution is more or less a continuous process, the program can be viewed as extending over three time periods.

- Langdon Clinic Phase: During this phase (10/31/85 to 2/28/92) the program operated under contract with the Langdon Clinic who developed and managed the SOTP. DOC had minimal involvement in program development and operation and management during this period.

- Transition Phase: There was a transition period as DOC was becoming more directly involved in the development and management of the SOTP. DOC contracted with separate providers directly, set up standards to screen and approve treatment providers and developed standards of care for treatment of sex offenders in the custody of DOC. During this period of overlap some offenders received treatment from both Langdon Clinic staff and other contract staff. The transition period was arbitrarily set at one year from 3/1/92 until 2/28/93.

- Current Period: The current period for the purpose of this data analysis is from 3/1/93 to 8/31/95.

The collection of data on program participants continues so that ongoing study of these offenders can occur. Data collection continues to get more refined as the program evolves and as analysis of the data continues. How data is analyzed in future studies may also change, with future research possibly grouping the data differently as the program evolves over time. It is conceivable that treatment effects vary according to the various time periods because of differences in staff and/or approach to treatment. This question can be addressed statistically. When no differences between the time periods appear, the data may be collapsed (combined) and analyzed as a whole. When there is no difference between time periods, it is better to collapse the data because there is greater power in the statistical tests when there is a larger sample size. It is then easier to detect if there is a real difference in any given result, rather than a result that occurred through chance. Additionally, analyzing data over time periods may help us to understand how the program is changing over time and whether the program changes which have been instituted have had the desired results. Figure 2 shows the percentage of sex offenders treated during the three time periods.

## D. Case Files

The amount of information available for analysis varied according to which of the treatment and control groups the offenders were in, as well as by the time periods when the offenders were in program. Sex offenders who were in the treatment group had a greater amount of information in their data file. More was learned about these offenders as a result of the assessment accomplished during the treatment process. A substantial amount of information is gathered on offenders in treatment that is simply not available for other inmates. Within the treatment group, more information was known about sex offenders in the current period (new files) than in the Langdon or transition periods (old files). The least amount of data was available for offenders in the control groups as there was no treatment file on these individuals.

## E. Release Information

Figure 3 shows the year in which the treated offenders were, or will be, released from prison. At the time of the study 82% of the treated offenders had been released.

## F. Definitions of Recidivism

Several measures of recidivism were used in the present study. These include the following:

- First Arrest - Any Offense: This variable is a measure of both sexual and non-sexual re-offenses. The time it took for an offender to be arrested for any offense is reflected in this figure.

- Most Serious Offense - Any Offense: This variable is also a measure of both sexual and non-sexual re-offenses but specifically determines the most serious of all re-offenses committed by an offender. This was determined by looking at NCIC offense codes and applying an algorithm to identify seriousness. The algorithm used was developed by the Bureau of Justice Statistics in the mid-1970's in an attempt to arrange the NCIC codes according to level of seriousness.

- First Arrest - Non-Sexual Offenses: This variable is a measure of re-offense for any non-sexual crime.

- Most Serious - Non-Sexual Offenses: This variable is a measure of the most serious of the non-sexual re-offenses, which is assessed using the algorithm described above.

- First Arrest - Sexual Offenses: This variable separates out sexual offenses from other offenses so that we can study the effects of treatment on sexual re-offending specifically.

- Most Serious Sexual Offense: This variable examines the most serious of the sexual re-offenses using the same algorithm as described above.

There is a range of criminal behavior which is reflected in the above definitions. Measures which reflect criminal behavior of any type tend to be the most sensitive since they pick up criminal thinking of any kind. Sexual re-offenses are the least sensitive since they are typically under reported. Non-sexual offenses, however, are related to sexual offenses because sexual offenses are often at the end of a chain of events which include non-sexual precursors. It is this chain of events which the relapse prevention plan addresses.

## G. Data Sources

Information about re-offenses was derived from the Alaska Public Safety Information Network (APSIN). A special program was created by the Department of Public Safety to extract re-arrest information on the offenders in the study. Any information of this type is bound to be an underestimate of actual criminal activity. Offenses are committed that are not detected. Some offenses that are detected do not result in a re-arrest. Many re-arrests do

not result in prosecution. Some that are prosecuted do not result in conviction. Additionally there are always doubts about the accuracy of any database. Data may not be entered into the system or it may be entered incorrectly. Most authorities in the research field indicate that a figure of about 80% accuracy is typical for a database such as APSIN. There has never been a study of the APSIN system to determine actual accuracy.

Another factor which effects the accuracy of current data is the fact that some offenders leave the State. Re-offense information is potentially available from an FBI database (Triple I). For a number of reasons it was not possible to gather Triple I data prior to this report.

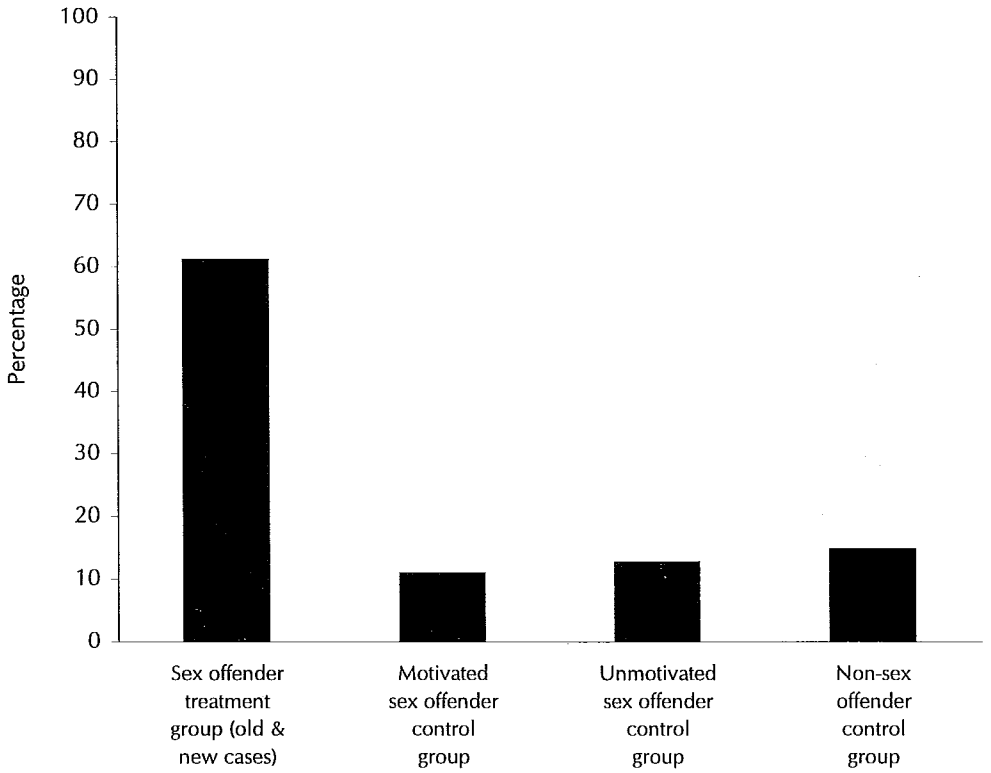
For all of the above reasons, the data in the present study is an estimate of re-offense events. Nevertheless, the comparative differences between groups will give us valuable information about program effectiveness.

## H. Statistical Analysis

The statistical procedure used to analyze reoffense data in the present study is survival analysis. This procedure, discussed by Marques, et al. (1994), accounts for the differential time that offenders are in the community. The longer that offenders are in community placement the greater the opportunity for re-offense The method, therefore, takes into consideration the fact that offenders have varying opportunity to re-offend. This technique is commonly used in medical research. The procedure yields a survival curve whereby groups can be compared for survival over time. The most effective methods will result in a greater percentage of survival. In the case of sex offenders, the results will compare survival rates between groups. In the present study, we would expect that treated offenders will survive at a higher rate than those offenders who were not treated.

There was also a great deal of demographic information, as well as information relating to the treatment process, which was analyzed. Whenever possible, this data was analyzed using appropriate statistical methods (e.g. Chi-Square) to determine if differences were statistically significant. Chi-Square is a statistical method of determining whether differences are more than what could be expected by chance. In some cases, statistical analysis was not possible due to insufficient numbers of subjects.

**Figure 1. Major Type of Case**

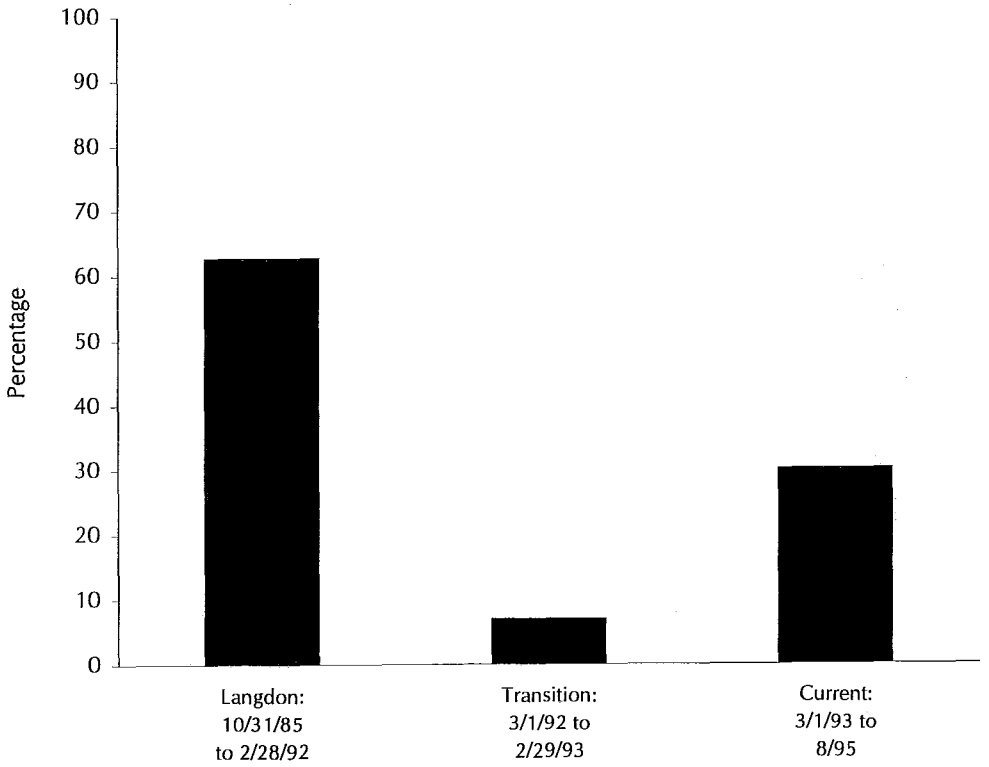



The project consists of 411 individuals who participated in the Hiland Mountain Correctional Center program at some level and three control groups of inmates to help put the information about the 411 into a frame of reference.

**Table 1. Major Type of Case**

| | N | % |
|---|---|---|
| Sex offender treatment group (old & new cases) | 411 | 61.3 % |
| Motivated sex offender control group | 74 | 11.0 |
| Unmotivated sex offender control group | 86 | 12.8 |
| Non-sex offender control group | 100 | 14.9 |
| **Total** | **671** | |

**Figure 2. Treatment Provider Period**

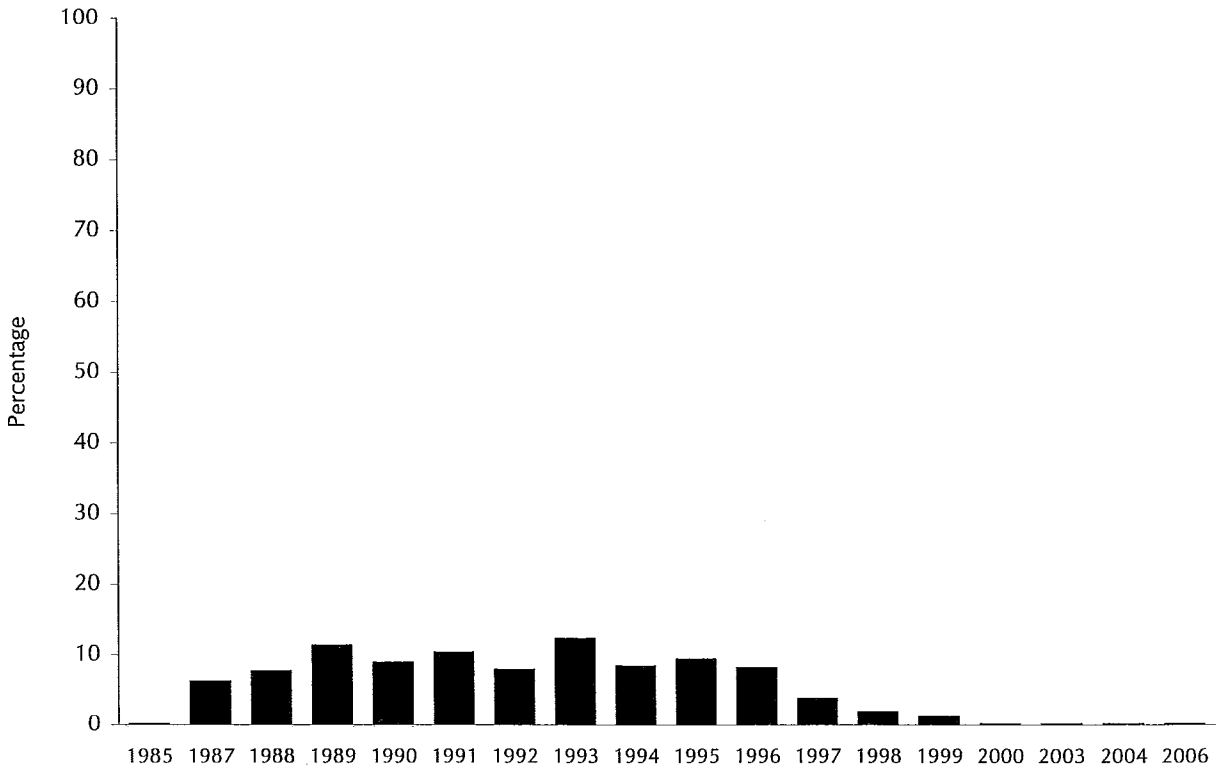



There has been a change in the contractual arrangement so that DOC currently has more involvement in the overall program management and hiring of staff.

**Table 2. Treatment Provider Period**

| | N | % |
|---|---|---|
| Langdon: 10/31/85 to 2/28/92 | 258 | 62.8 % |
| Transition: 3/1/92 to 2/29/93 | 29 | 7.1 |
| Current: 3/1/93 to 8/95 | 124 | 30.2 |
| **Total** | **411** | |

## Figure 3. Projected Year of Release




Of the treated inmates, approximately 18 percent had not been released from prison at the time of the study.

**Table 3. Projected Year of Release**

| | N | % | Cumulative % | | N | % | Cumulative % |
|---|---|---|---|---|---|---|---|
| 1985 | 1 | 0.2 % | 0.2 % | 1996 | 34 | 8.3 % | 92.0 % |
| 1987 | 26 | 6.3 | 6.6 | 1997 | 16 | 3.9 | 95.9 |
| 1988 | 32 | 7.8 | 14.4 | 1998 | 8 | 1.9 | 97.8 |
| 1989 | 47 | 11.4 | 25.8 | 1999 | 5 | 1.2 | 99.0 |
| 1990 | 37 | 9.0 | 34.8 | 2000 | 1 | 0.2 | 99.3 |
| 1991 | 43 | 10.5 | 45.3 | 2003 | 1 | 0.2 | 99.5 |
| 1992 | 33 | 8.0 | 53.3 | 2004 | 1 | 0.2 | 99.8 |
| 1993 | 51 | 12.4 | 65.7 | 2006 | 1 | 0.2 | 100.0 |
| 1994 | 35 | 8.5 | 74.2 | | | | |
| 1995 | 39 | 9.5 | 83.7 | **Total** | **411** | | |

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# V. Results

## A. Descriptive Information

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# V. Results

Findings reported in this section are divided into three major areas. The first gives a descriptive account of offenders who participated in the treatment program. Basic demographic information is given to describe the offenders. This helps us to understand "who" the participants were with respect to race, age, education level, marital status and so forth. The second section tells us something about program variables, i.e. what was "done" in treatment with respect to how long offenders remained in treatment, how far they progressed, and under what conditions they were discharged. The third and final section gives information about re-offense. This tells us something about the effectiveness of the program with respect to how long the offenders "survived" compared to control groups.[1]

## A. Descriptive Information

Descriptive information about the offenders studied is provided in Figures 4 through 17 and addresses the following variables:

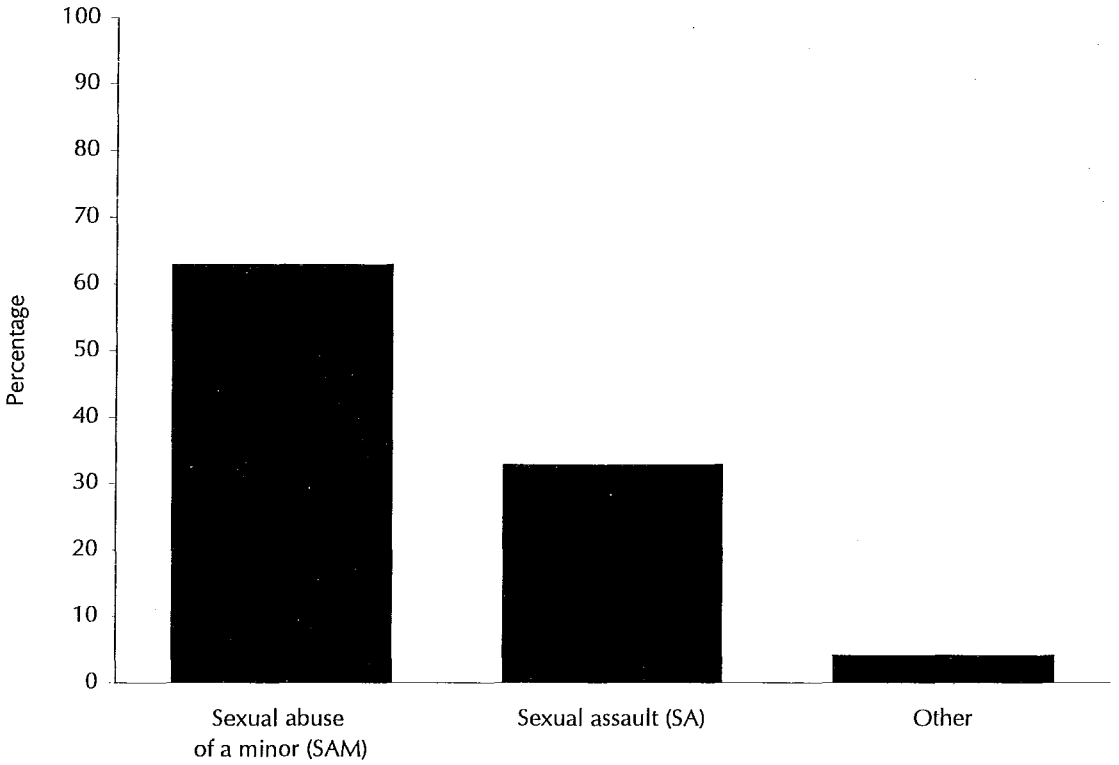
- Major Type of Offense
- Judicial District of Offense
- Length of Sentence
- Presumptive Sentencing
- Race
- Age of Offenders
- Marital Status
- Occupation of Offender
- Level of Education
- Substance Abuse

**Summary of Descriptive Findings**

The majority of the sex offenders in the treatment group have committed crimes against children. Over half had been convicted in the Third Judicial District and almost all received sentences of over two years. Sixty percent (60 %) were sentenced to 7 years or less. Almost half of the sentences were presumptive. About one-half of the offenders were White and 38% Alaska Native. Almost one-half of the offenders were under age 35 with Sexual Assault (SA) offenders being younger than Sexual Abuse of a Minor (SAM) offenders. Also, Alaska Native offenders tended to be younger than their White counterparts. Almost 40% of the offenders were single and about 30% were married at the time of their offenses. Most offenders were in occupations classified as skilled or unskilled labor at the time of offense. Nearly two-thirds had a high school education or its equivalent. Sixty-seven percent (67%) had a history of substance abuse. The incidence of substance abuse was much higher among Alaska Native offenders. There was insufficient data to draw any firm conclusions about the role of substance abuse at the time of the instant offense.

[1] "Missing" Information/Data: In some cases, a given data element was unavailable in the database. This is reflected in the figures on the following pages. It was not always possible to find the missing data, particularly in the case of offenders who have left the system.

## Figure 4. Offense Category




Of the 411 inmates in the treatment program, the majority (63.0%) were convicted of some form of sexual abuse of a minor. The "other" category includes crimes that were difficult to classify under the other two headings or sexual crimes that were charge-bargained.

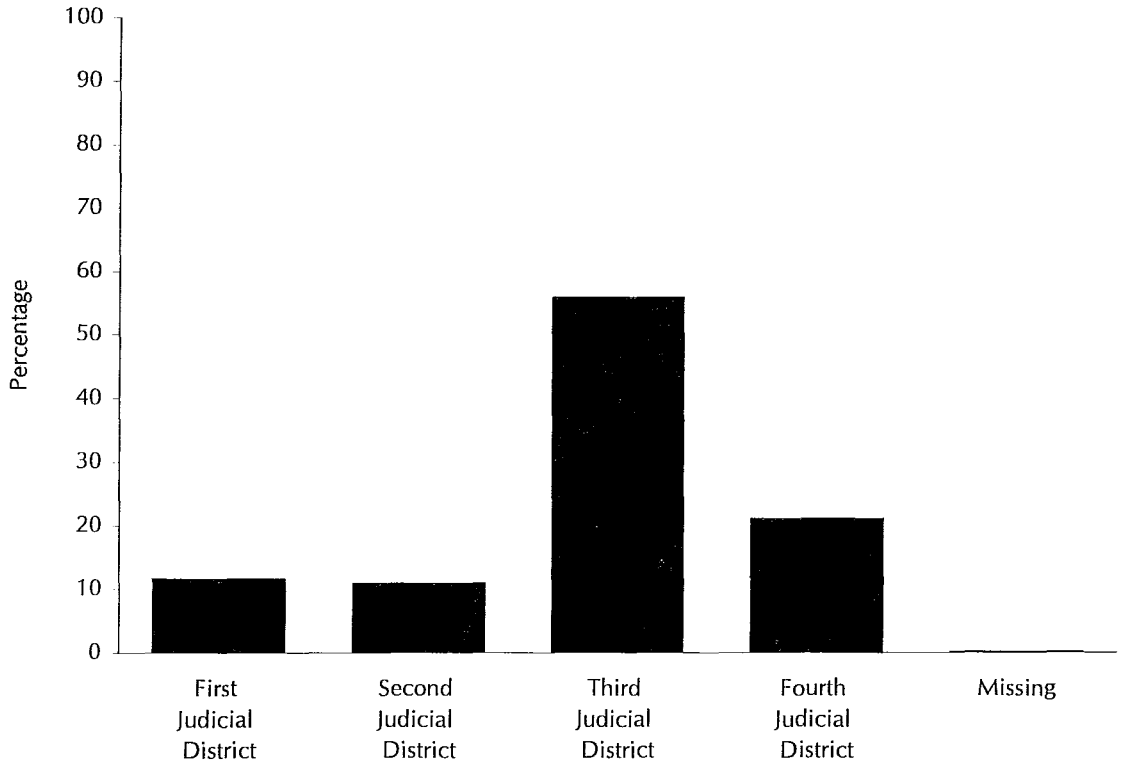
**Table 4a. Offense Category**

| | N | % |
|---|---|---|
| Sexual abuse of a minor (SAM) | 259 | 63.0 % |
| Sexual assault (SA) | 135 | 32.8 |
| Other | 17 | 4.1 |
| **Total** | **411** | |

## Table 4b. OBSCIS Offense Code

| Offense | Code | N | % |
|---|---|---|---|
| **Sexual abuse of a minor (SAM)** | **Total** | **259** | **63.0 %** |
| Sexual abuse of a minor 1 | 41.434 | 95 | 23.1 |
| Sexual abuse of a minor 2 | 41.436 | 118 | 28.7 |
| Sexual abuse of a minor 3 | 41.438 | 8 | 1.9 |
| Sexual abuse of a minor 4 | 41.440 | 9 | 2.2 |
| Incest | 41.450 | 2 | 0.5 |
| Attempted sexual abuse of a minor 1 | 941.434 | 20 | 4.9 |
| Attempted sexual abuse of a minor 2 | 941.436 | 6 | 1.5 |
| Attempted sexual abuse of a minor 3 | 941.438 | 1 | 0.2 |
| **Sexual assault (SA)** | **Total** | **135** | **32.8 %** |
| Sexual assault 1 | 41.410 | 86 | 20.9 |
| Sexual assault 2 | 41.420 | 27 | 6.6 |
| Sexual assault 3 | 41.425 | 1 | 0.2 |
| Sexual assault 3 (old) | 41.430 | 1 | 0.2 |
| Attempted sexual assault 1 | 941.410 | 19 | 4.6 |
| Attempted sexual assault 2 | 941.420 | 1 | 0.2 |
| **Other offenses** | **Total** | **17** | **4.1 %** |
| Offense against the person (old) | 15.120 | 2 | 0.5 |
| Offense against the person (old) | 15.160 | 1 | 0.2 |
| Attempt to commit a crime | 31.100 | 1 | 0.2 |
| Assault 1 | 41.200 | 1 | 0.2 |
| Assault 2 | 41.210 | 2 | 0.5 |
| Assault 4 | 41.230 | 2 | 0.5 |
| Kidnapping | 41.300 | 3 | 0.7 |
| Exploitation of a minor | 41.455 | 3 | 0.7 |
| Coercion | 41.530 | 1 | 0.2 |
| Burglary 1 | 46.300 | 1 | 0.2 |
| | **Total** | **411** | |

## Figure 5. Location of Court of Conviction



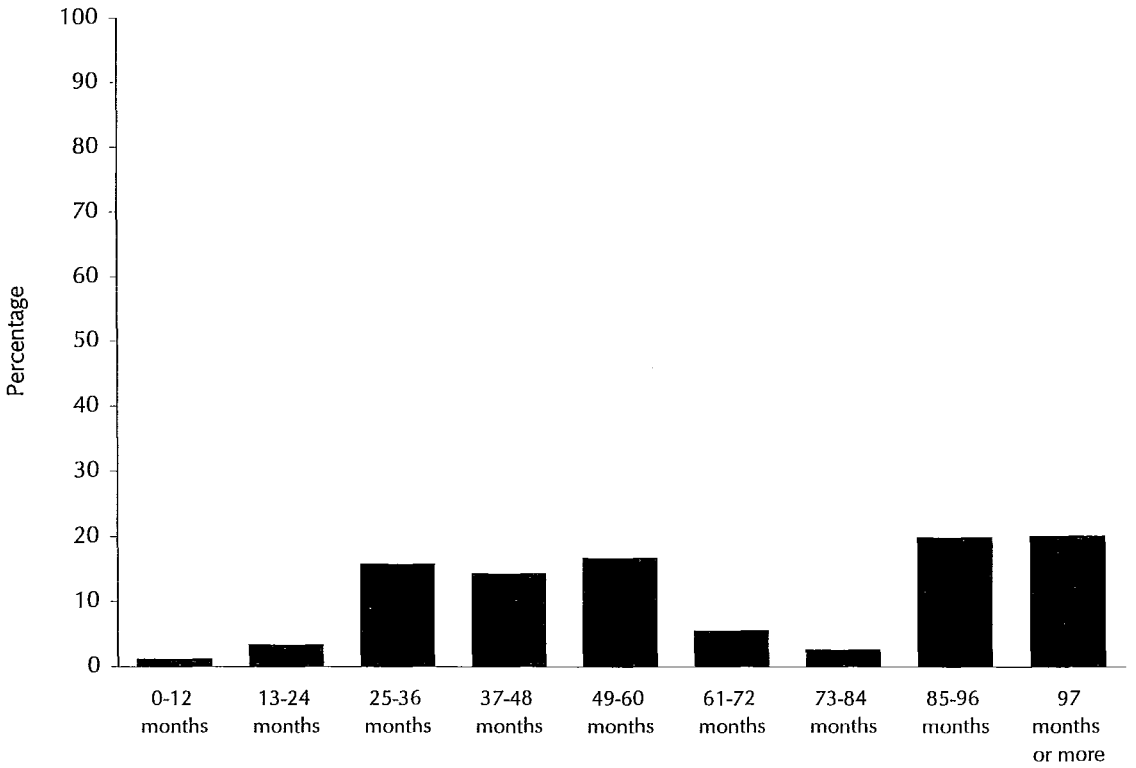

The highest number of participants in the Hiland Mountain Sex Offenders Treatment Program were tried in the Third Judicial District (56.0%).

**Table 5. Location of Court of Conviction**

| | N | % |
|---|---|---|
| First Judicial District | 48 | 11.7 % |
| Second Judicial District | 45 | 10.9 |
| Third Judicial District | 230 | 56.0 |
| Fourth Judicial District | 87 | 21.2 |
| Missing | 1 | 0.2 |
| **Total** | **411** | |

## Figure 6. Length of Sentence

*12 month intervals*




Most (95%) of the inmates in this program received sentences of more than two years. Approximately 60 percent received sentences of more than seven years.

### Table 6a. Length of Sentence

*12 month intervals*

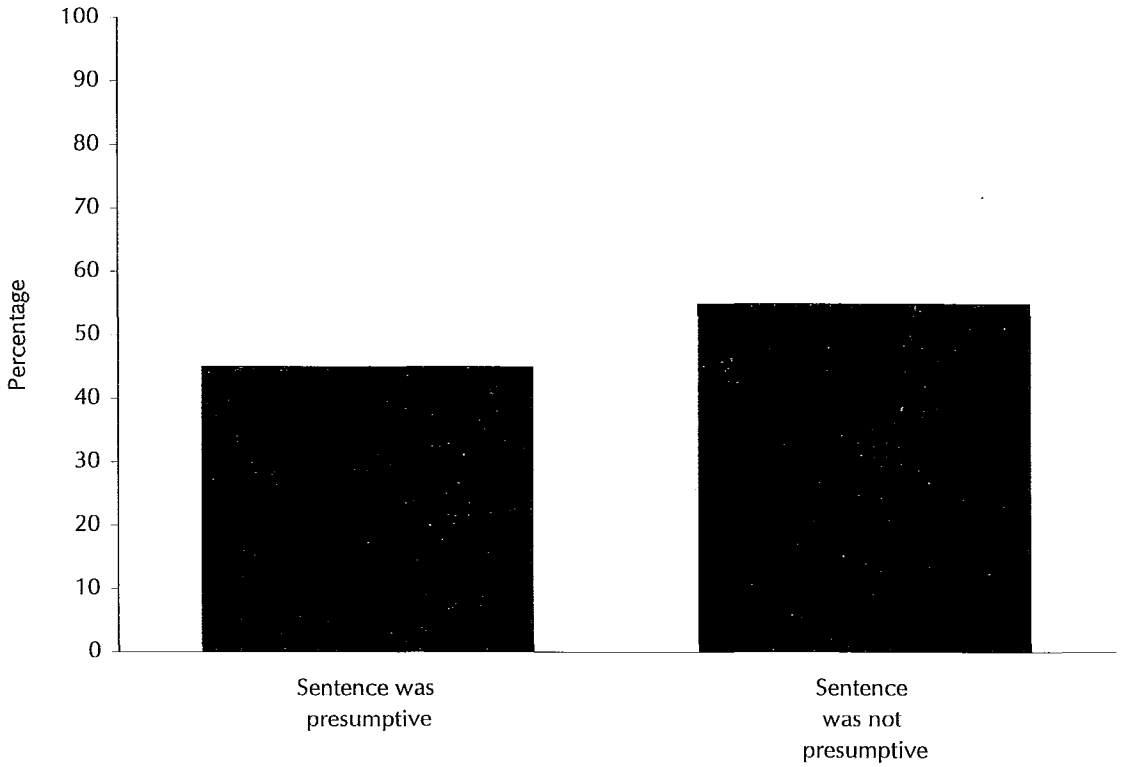
| | N | % |
|---|---|---|
| 0 to 12 months | 5 | 1.2 % |
| 13 to 24 months | 14 | 3.4 |
| 25 to 36 months | 65 | 15.8 |
| 37 to 48 months | 59 | 14.4 |
| 49 to 60 months | 69 | 16.8 |
| 61 to 72 months | 23 | 5.6 |
| 73 to 84 months | 11 | 2.7 |
| 85 to 96 months | 82 | 20.0 |
| 97 months or more | 83 | 20.2 |
| **Total** | **411** | |

## Table 6b. Length of Sentence

*Actual sentence length*

| | N | % | | N | % |
|---|---|---|---|---|---|
| 6 months | 1 | 0.2 % | 90 months | 1 | 0.2 % |
| 10 months | 1 | 0.2 | 96 months | 81 | 19.7 |
| 12 months | 3 | 0.7 | 97 months | 2 | 0.5 |
| 18 months | 5 | 1.2 | 98 months | 3 | 0.7 |
| 20 months | 1 | 0.2 | 99 months | 1 | 0.2 |
| 22 months | 1 | 0.2 | 102 months | 1 | 0.2 |
| 24 months | 7 | 1.7 | 108 months | 8 | 1.9 |
| 26 months | 1 | 0.2 | 114 months | 3 | 0.7 |
| 27 months | 1 | 0.2 | 120 months | 24 | 5.8 |
| 30 months | 17 | 4.1 | 126 months | 1 | 0.2 |
| 32 months | 1 | 0.2 | 132 months | 2 | 0.5 |
| 34 months | 1 | 0.2 | 144 months | 8 | 1.9 |
| 36 months | 44 | 10.7 | 156 months | 5 | 1.2 |
| 39 months | 1 | 0.2 | 171 months | 1 | 0.2 |
| 42 months | 6 | 1.5 | 174 months | 1 | 0.2 |
| 44 months | 1 | 0.2 | 180 months | 11 | 2.7 |
| 48 months | 51 | 12.4 | 185 months | 1 | 0.2 |
| 51 months | 1 | 0.2 | 186 months | 1 | 0.2 |
| 54 months | 4 | 1.0 | 192 months | 1 | 0.2 |
| 55 months | 1 | 0.2 | 228 months | 1 | 0.2 |
| 56 months | 1 | 0.2 | 240 months | 3 | 0.7 |
| 57 months | 1 | 0.2 | 300 months | 2 | 0.5 |
| 60 months | 61 | 14.8 | 324 months | 1 | 0.2 |
| 66 months | 3 | 0.7 | 360 months | 1 | 0.2 |
| 72 months | 20 | 4.9 | 480 months | 1 | 0.2 |
| 74 months | 1 | 0.2 | | | |
| 75 months | 1 | 0.2 | | | |
| 78 months | 2 | 0.5 | | | |
| 84 months | 7 | 1.7 | **Total** | **411** | |

## Figure 7. Presumptive Sentencing

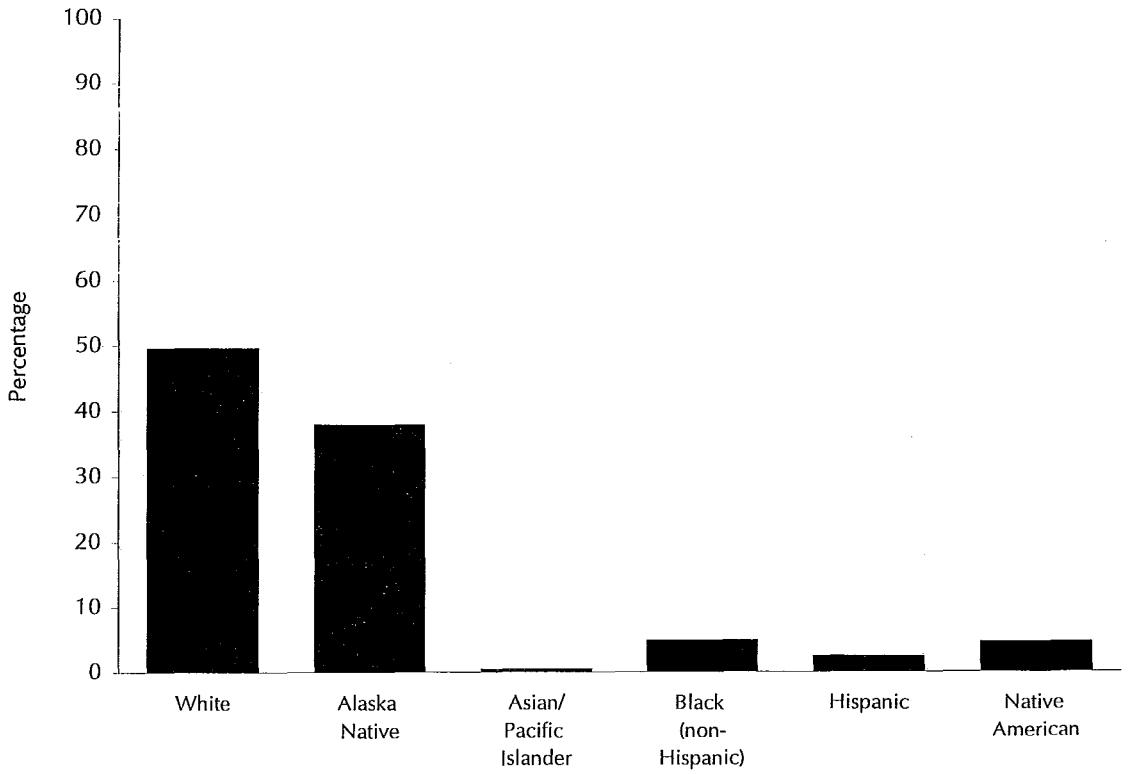



Less than half (45.0%) of the inmates associated with the program were serving a presumptive sentence.

**Table 7. Presumptive sentencing**

| | | |
|---|---|---|
| Sentencing was presumptive | 185 | 45.0 % |
| Sentencing was not presumptive | 226 | 55.0 |
| **Total** | **411** | |

## Figure 8. Race

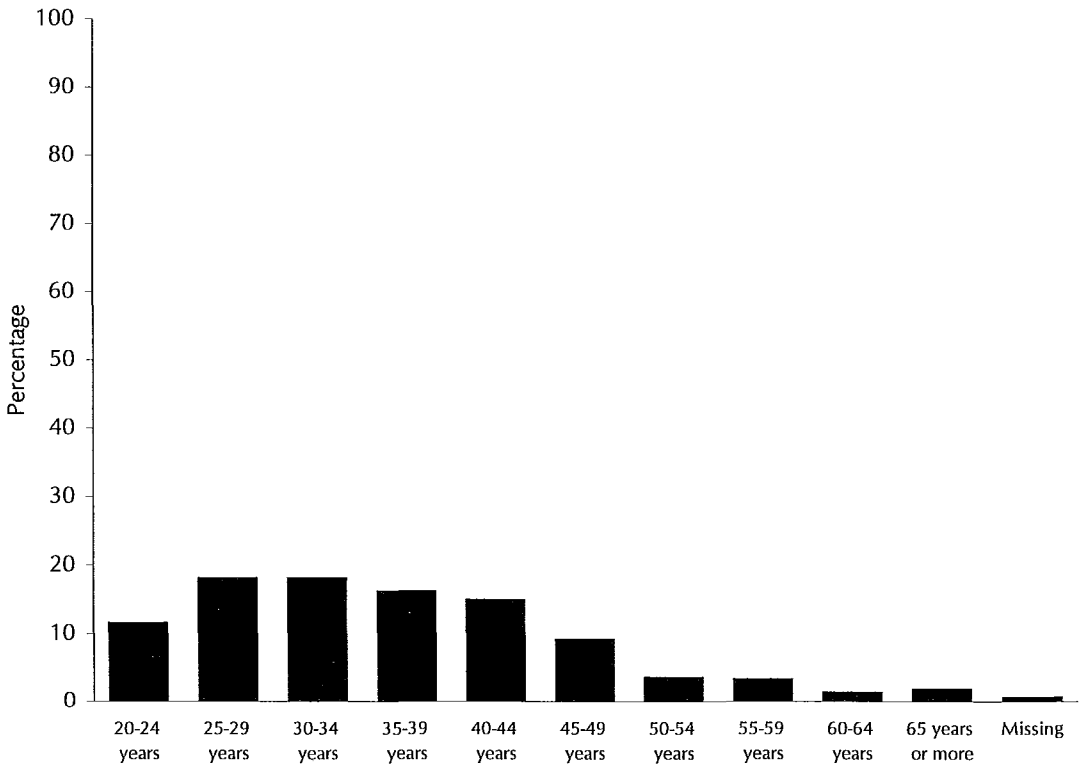



Just under one-half (49.6%) of the inmates who came into contact with the program were white. The next highest racial group (38.0%) were Alaska Natives (this group includes individuals of Eskimo, Aleut, Athabascan, Haida, Tlingit, and mixed Alaska Native backgrounds).

### Table 8. Race

| | N | % |
|---|---|---|
| **White** | **204** | **49.6 %** |
| **Alaska Native** | **156** | **38.0 %** |
| Eskimo (unspecified) | 58 | 14.1 |
| Yup'ik Eskimo | 36 | 8.8 |
| Inupiat Eskimo | 12 | 2.9 |
| Aleut | 24 | 5.8 |
| Athabascan | 7 | 1.7 |
| Haida | 2 | 0.5 |
| Tlingit | 16 | 3.9 |
| Mixed Alaska Native | 1 | 0.2 |
| **Asian/Pacific Islander** | **2** | **0.5 %** |
| **Black (non-Hispanic)** | **20** | **4.9 %** |
| **Hispanic** | **10** | **2.4 %** |
| **Native American** | **19** | **4.6 %** |
| **Total** | **411** | |

## Figure 9. Age at Treatment Program Discharge



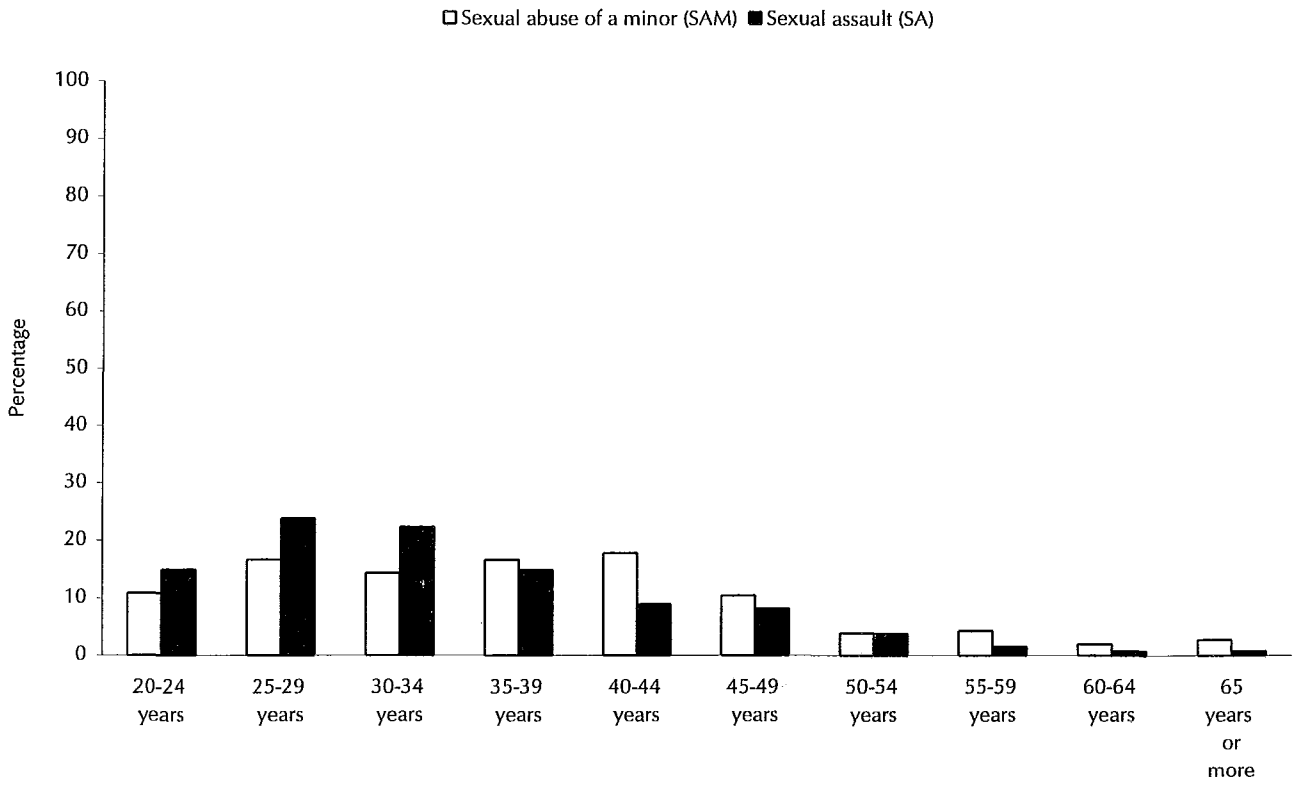

Almost half of the program participants (48%) were under 35 years of age.

### Table 9. Age at Treatment Program Discharge

| | N | % |
|---|---|---|
| 20-24 years | 48 | 11.7 % |
| 25-29 years | 75 | 18.2 |
| 30-34 years | 75 | 18.2 |
| 35-39 years | 67 | 16.3 |
| 40-44 years | 62 | 15.1 |
| 45-49 years | 38 | 9.2 |
| 50-54 years | 15 | 3.6 |
| 55-59 years | 14 | 3.4 |
| 60-64 years | 6 | 1.5 |
| 65 years or more | 8 | 1.9 |
| Missing | 3 | 0.7 |
| **Total** | **411** | |

## Figure 10. Age at Discharge from Program by Major Offense Category

*SAM and SA offenders only.*




The offenders committing sexual assaults (SA) are younger compared to the offenders committing sexual abuse of minor (SAM) offenses. The most frequent age group for SA offenders is 25 to 29, whereas the most frequent age category for SAM offenders is 40 to 44.

## Table 10. Age at Discharge from Program by Major Offense Category

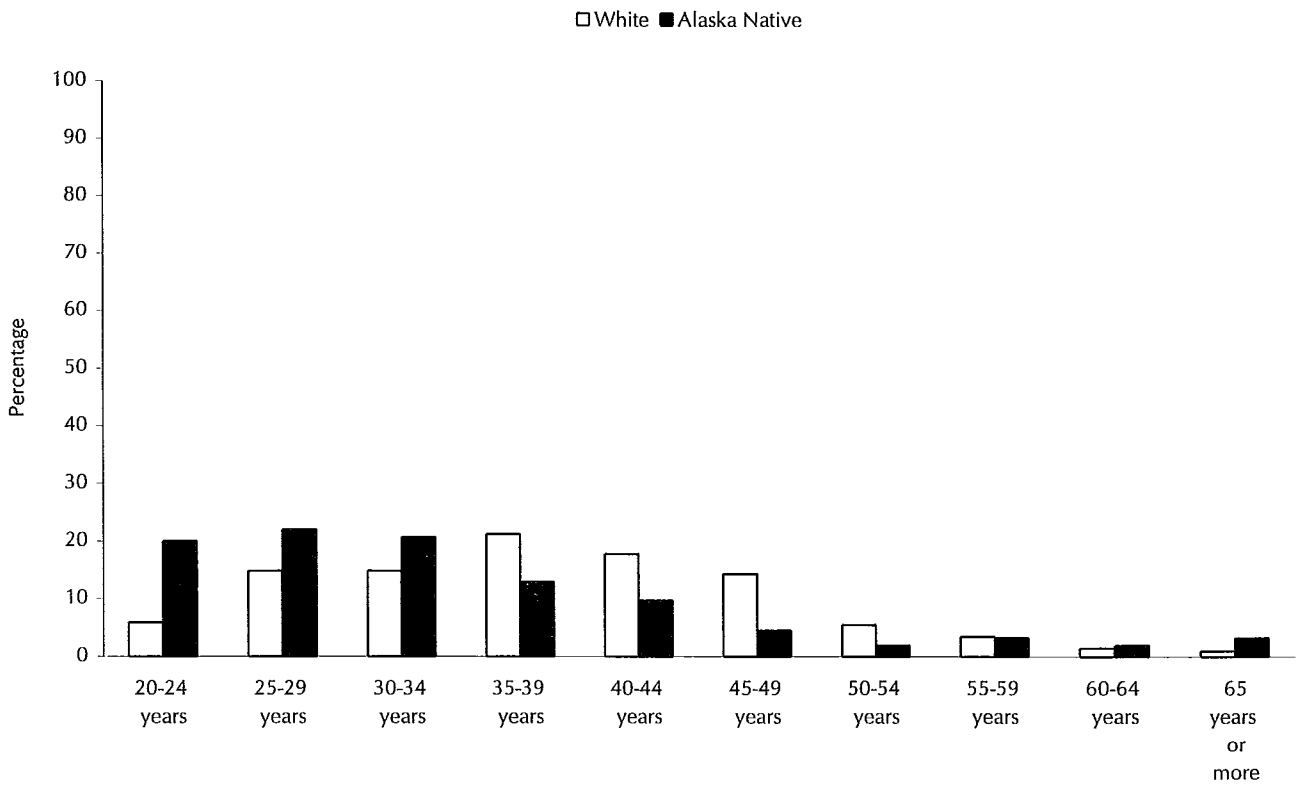
*SAM and SA offenders only.*

| | Sexual abuse of a minor (SAM) | | Sexual assault (SA) | |
|---|---|---|---|---|
| | N | % | N | % |
| 20-24 years | 28 | 10.9 % | 20 | 14.9 % |
| 25-29 years | 43 | 16.7 | 32 | 23.9 |
| 30-34 years | 37 | 14.4 | 30 | 22.4 |
| 35-39 years | 43 | 16.7 | 20 | 14.9 |
| 40-44 years | 46 | 17.9 | 12 | 9.0 |
| 45-49 years | 27 | 10.5 | 11 | 8.2 |
| 50-54 years | 10 | 3.9 | 5 | 3.7 |
| 55-59 years | 11 | 4.3 | 2 | 1.5 |
| 60-64 years | 5 | 1.9 | 1 | 0.7 |
| 65 years or more | 7 | 2.7 | 1 | 0.7 |
| **Total** | **257** | | **134** | |

*Age at program discharge was missing for two SAM and one SA offender, who are excluded from this table.*

## Figure 11. Age at Discharge from Program by Race

*Whites and Alaska Natives only.*




Alaska Native offenders tended to be younger than Caucasian offenders. The most frequent age for Native offenders was about 27 years, whereas the most frequent age for white offenders was about 10 years older.

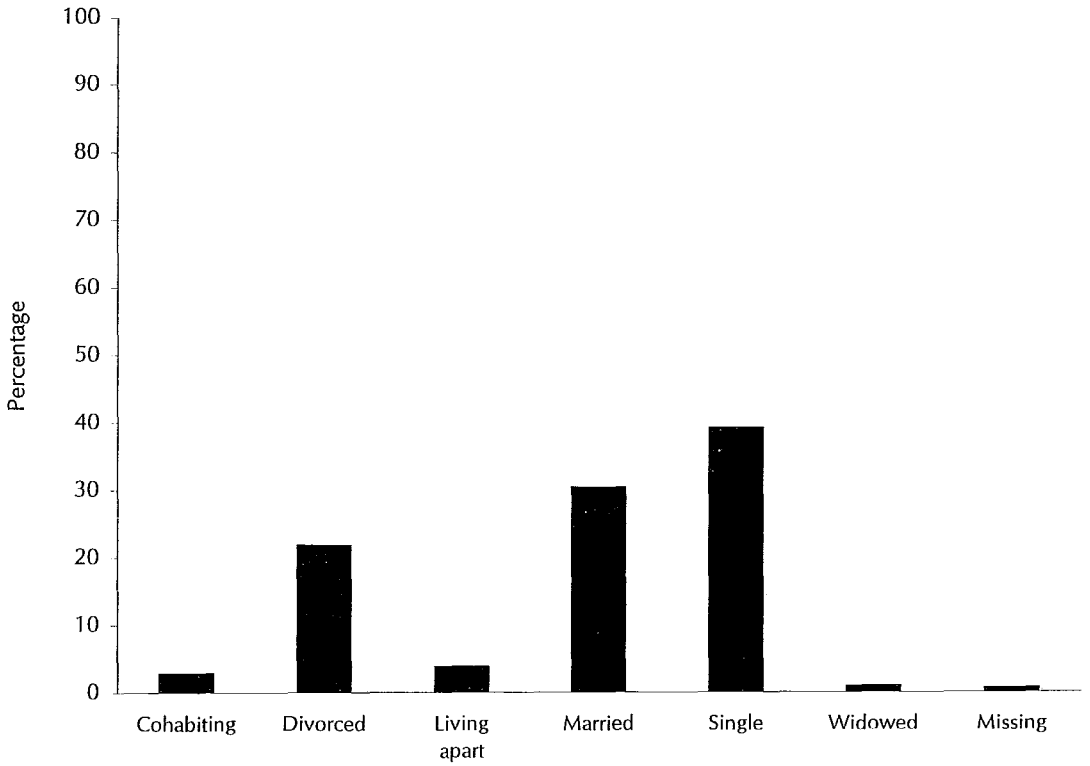
### Table 11. Age at Discharge from Program by Race

*Whites and Alaska Natives only.*

| | White | | Alaska Native | |
|---|---|---|---|---|
| | N | % | N | % |
| 20-24 years | 12 | 5.9 % | 31 | 20.0 % |
| 25-29 years | 30 | 14.8 | 34 | 21.9 |
| 30-34 years | 30 | 14.8 | 32 | 20.6 |
| 35-39 years | 43 | 21.2 | 20 | 12.9 |
| 40-44 years | 36 | 17.7 | 15 | 9.7 |
| 45-49 years | 29 | 14.3 | 7 | 4.5 |
| 50-54 years | 11 | 5.4 | 3 | 1.9 |
| 55-59 years | 7 | 3.4 | 5 | 3.2 |
| 60-64 years | 3 | 1.5 | 3 | 1.9 |
| 65 years or more | 2 | 1.0 | 5 | 3.2 |
| **Total** | **203** | | **155** | |

*Age at program discharge was missing for one white and one Native inmate, who are exluded from this table.*

## Figure 12. Marital Status at Instant Offense

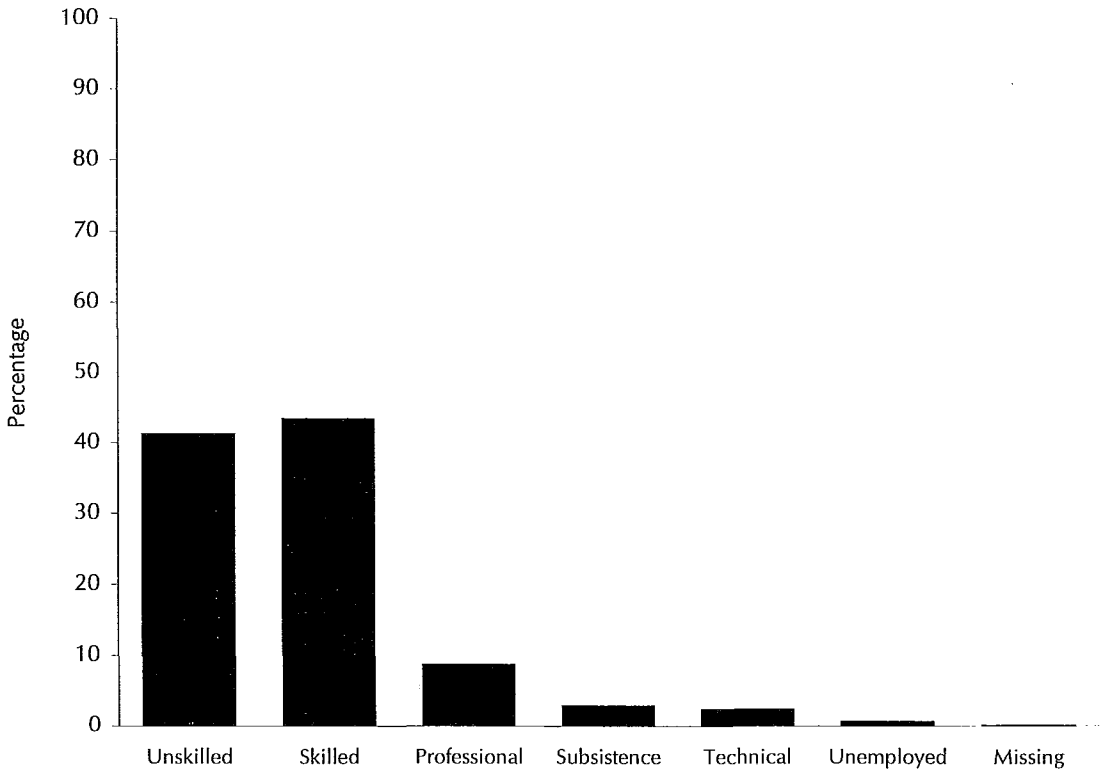



Almost 40 percent of the inmates were single at the time of the instant offense. About 30 percent were married.

**Table 12. Marital Status at Instant Offense**

| | N | % |
|---|---|---|
| Cohabiting | 12 | 2.9 % |
| Divorced | 90 | 21.9 |
| Living apart | 16 | 3.9 |
| Married | 125 | 30.4 |
| Single | 161 | 39.2 |
| Widowed | 4 | 1.0 |
| Missing | 3 | 0.7 |
| **Total** | **411** | |

## Figure 13. Occupation

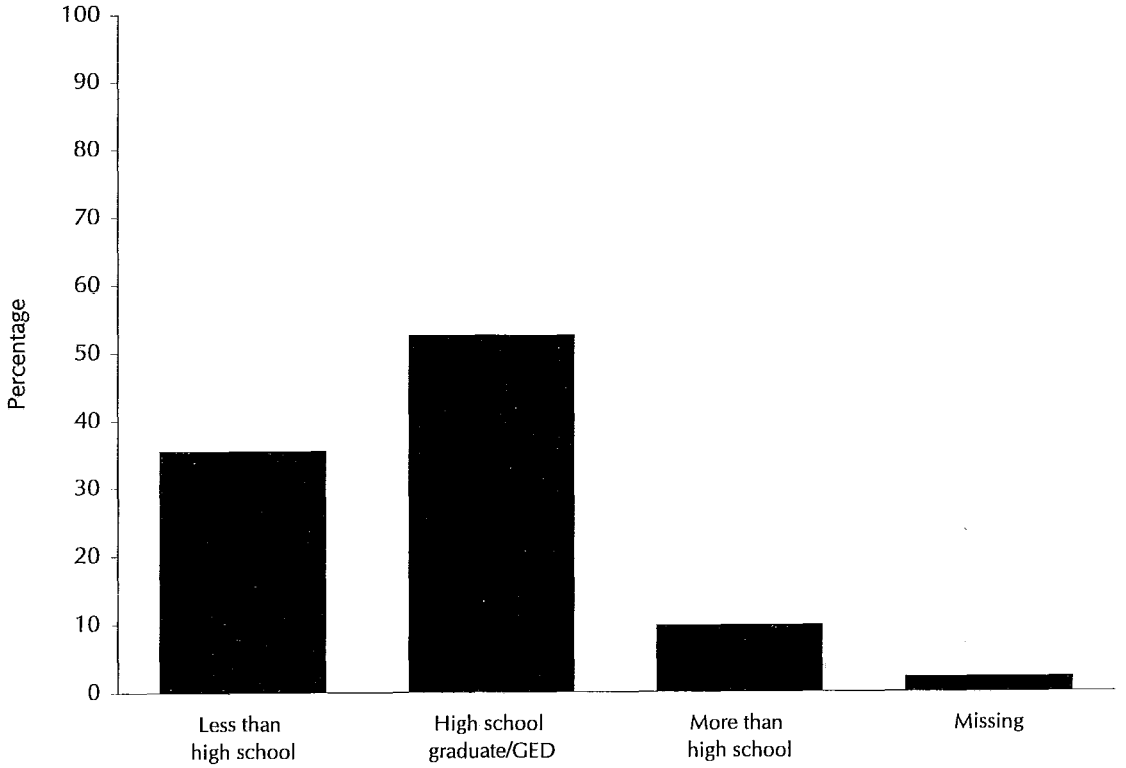



Most offenders in the program were classified either as unskilled labor (41.4%) or skilled labor (43.6%).

**Table 13. Occupation**

| | N | % |
|---|---|---|
| Unskilled | 170 | 41.4 % |
| Skilled | 179 | 43.6 |
| Professional | 36 | 8.8 |
| Subsistence | 12 | 2.9 |
| Technical | 10 | 2.4 |
| Unemployed | 3 | 0.7 |
| Missing | 1 | 0.2 |
| **Total** | **411** | |

## Figure 14. Education



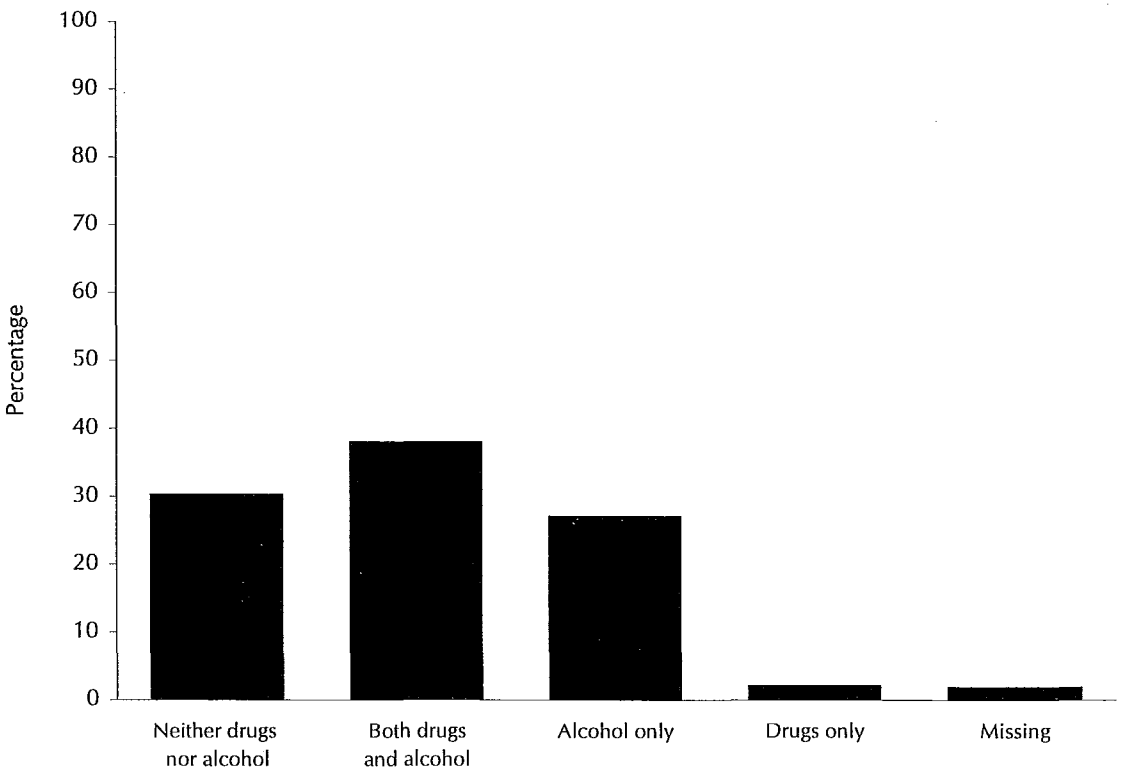

Nearly two-thirds (62.3%) of the sex offenders who had contact with the program had an educational level of high school diploma/GED equivalency or higher.

### Table 14. Education

*Highest grade completed.*

| | N | % |
|---|---|---|
| Less than high school | 146 | 35.5 % |
| High school graduate/GED | 216 | 52.6 % |
| More than high school | 40 | 9.7 % |
| Missing | 9 | 2.2 % |
| **Total** | **411** | |

## Figure 15. Substance Abuse History

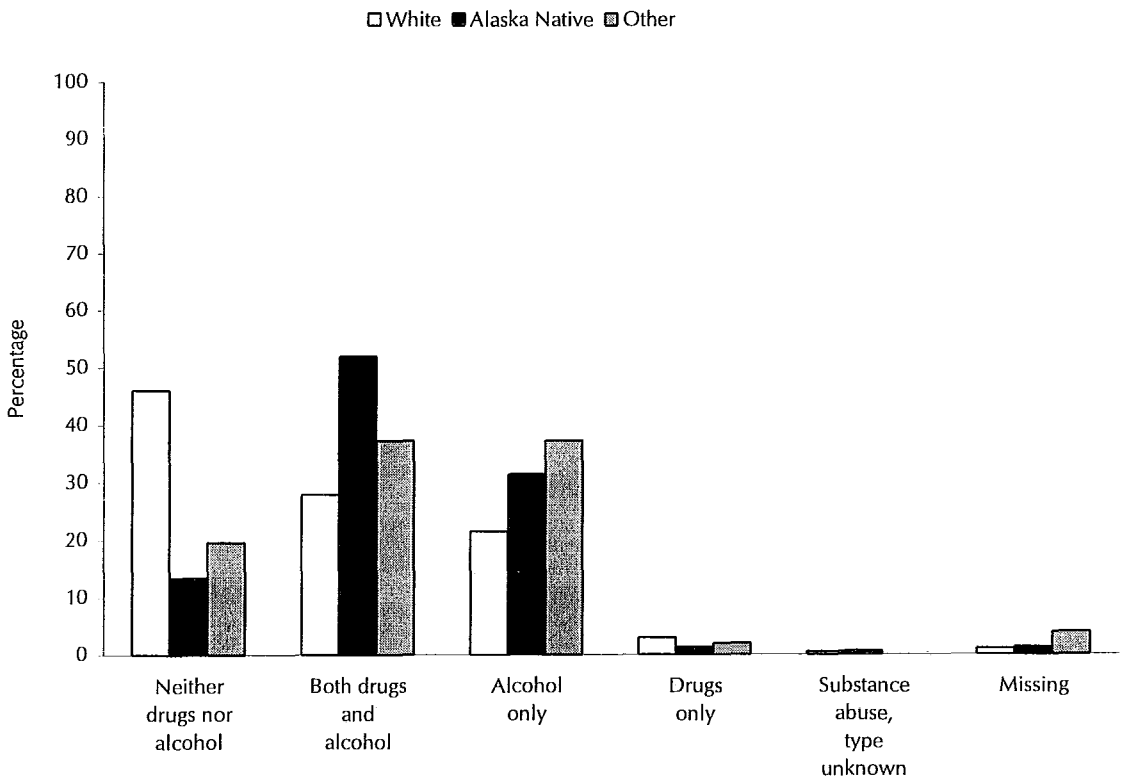



The majority of inmates in the program indicated a history of alcohol or drug abuse or both (67.6%). However, nearly one-third of the inmates (30.4%) resported no history of either drug or alcohol abuse.

**Table 15. Substance Abuse History**

| | N | % |
|---|---|---|
| Neither drugs nor alcohol | 125 | 30.4 % |
| Both drugs and alcohol | 157 | 38.2 |
| Alcohol only | 112 | 27.3 |
| Drugs only | 9 | 2.2 |
| Missing | 8 | 1.9 |
| **Total** | **411** | |

## Figure 16. Substance Abuse History by Race

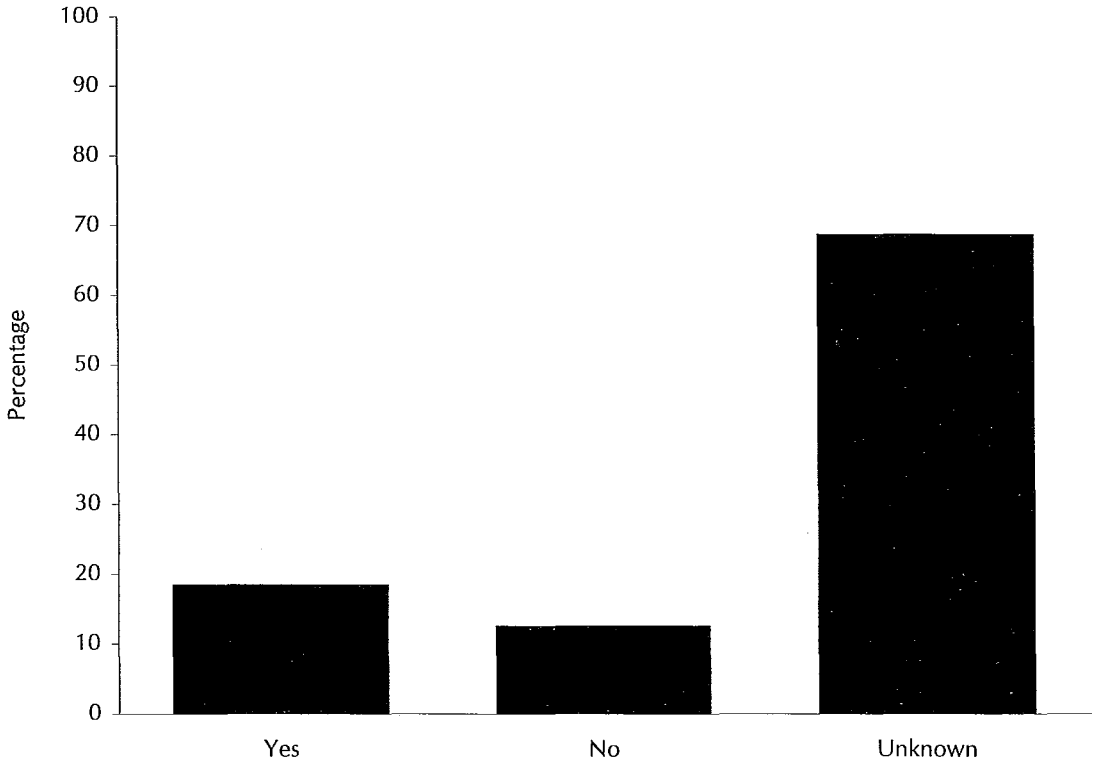



There was a higher incidence of substance abuse among Alaska Native participants. Of white participants in the program 46 percent reported no alcohol or drug abuse, while only 14 percent of the Alaska Natives and 20 percent of the other races reported no substance abuse.

### Table 16. Substance Abuse History by Race

| | White | | Alaska Native | | Other | |
|---|---|---|---|---|---|---|
| | N | % | N | % | N | % |
| Neither drugs nor alcohol | 94 | 46.1 % | 21 | 13.5 % | 10 | 19.6 % |
| Both drugs and alcohol | 57 | 27.9 | 81 | 51.9 | 19 | 37.3 |
| Alcohol only | 44 | 21.6 | 49 | 31.4 | 19 | 37.3 |
| Drugs only | 6 | 2.9 | 2 | 1.3 | 1 | 2.0 |
| Substance abuse, type unknown | 1 | 0.5 | 1 | 0.6 | 0 | 0.0 |
| Missing | 2 | 1.0 | 2 | 1.3 | 2 | 3.9 |
| **Total** | **204** | | **156** | | **51** | |

## Figure 17. Substance Abuse at Instant Offense




There were limited data on substance abuse at the time of the instant offense. Data for most of the offenders were unavailable because this information was not recorded in many files, especially the old case files.

**Table 17. Substance Abuse at Instant Offense**

| | N | % |
|---|---|---|
| Yes | 76 | 18.5 % |
| No | 52 | 12.7 |
| Unknown | 283 | 68.9 |
| **Total** | **411** | |

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# V. Results

## B. Treatment Variables

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## B. Treatment Variables

There are three primary treatment variables under study, including: Time in Treatment; Treatment Stage Attained; and, Reason for Discharge. These variables reflect not merely what is offered the offender during the treatment process, but also the degree to which the offender accepts or incorporates what is offered. In order to benefit from treatment it is necessary for an offender to actively participate for an optimal length of time. On the one hand, the number of months in treatment might be viewed as if it were a dosage, assuming that treatment is cumulative in a quantitative sense; on the other hand, the mere passage of time is not sufficient to achieve a qualitative change. The discrimination between treatment stages at discharge (Beginning, Intermediate, and Advanced) are clinical determinations that the offender has made qualitative changes by accepting what is offered.

The reasons for discharge are grouped into four categories: ATA (left against treatment advice)/Quit program; Removed/Dismissed by the treatment team; Sentence Complete; and, Program Complete. The reasons for discharge, along with the variable stage at discharge, allow us to make some conclusions about how much of treatment has been incorporated.

How well the offenders do upon release is connected to these primary variables, i.e. the length of time in program, the treatment stage obtained, and the reason for discharge from the program.

Each of the primary treatment variables was also studied in relation to demographic variables. The demographic variables help us to individualize the treatment.

### 1. Time in Program

Treatment variables related to Time in Program are presented in Figures 18 through 22.

**Summary of Findings for Time in Program**

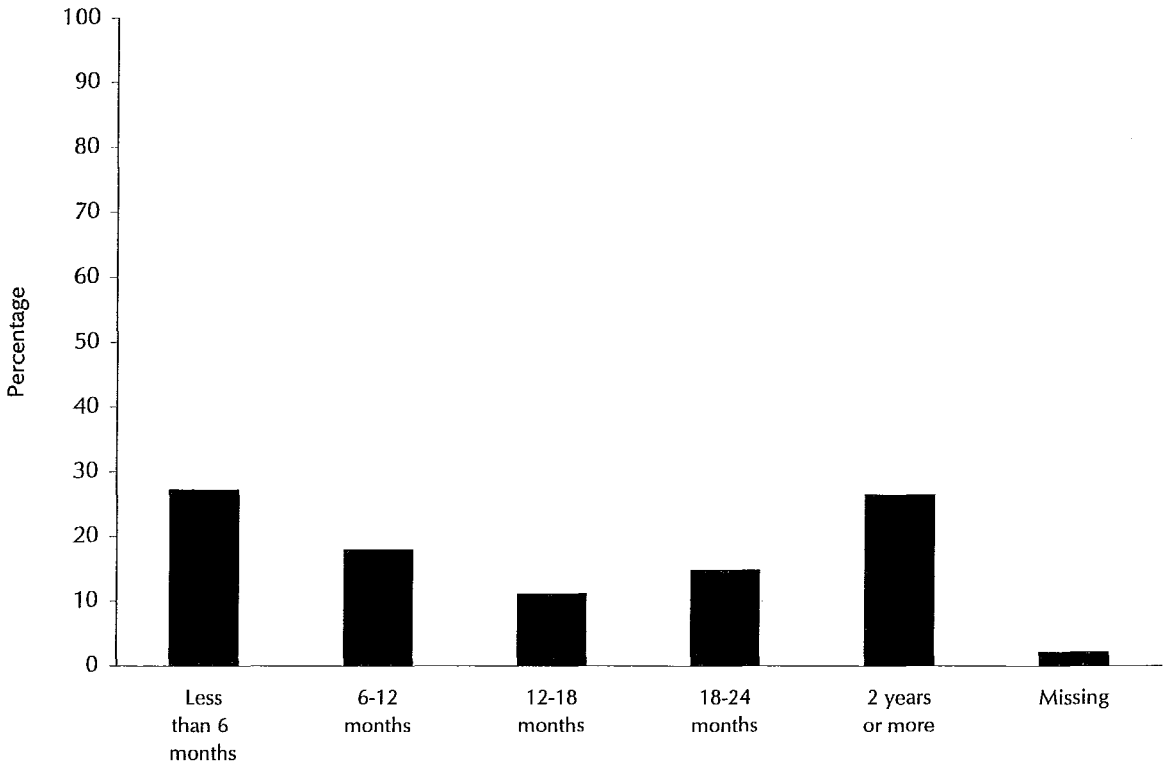
Results show that a number of offenders leave program in the first six to twelve months. This reflects the program's second level of screening when offenders actually have the opportunity to participate in the program. Some choose not to participate and leave program against treatment advice and others may be removed by staff because of lack of involvement. Those who choose to work at treatment tend to stay two years or longer. There was a large difference in the range of time spent in program for those in the treatment group. At least one offender was only in the program for four days, while one other offender was in the program for over 2,000 days. About 25% of the offenders had been in program for six months or less. The average stay in the program was 17 months.

Results also indicate that Alaska Natives spend significantly less time in program than Caucasians. A larger number of Alaska Natives are leaving in the first six months. The reasons for this will be explored further in later sections of this paper. When considering the amount of time it takes Alaska Natives and Caucasians to complete the beginning phase of treatment, however, there is no statistical difference. This tells us that the Alaska Native offenders who stay in treatment finish this phase in about the same time.

It is interesting that offenders who abuse neither alcohol or drugs tend to remain in treatment longer. Conversely, those who abuse both substances leave program earlier. This is consistent with the clinical observation that these individuals tend to be somewhat more impulsive.

Most sex offender programs report a lower success rate with SA offenders than with SAM offenders, with many showing that these individuals have a tendency to leave treatment sooner. Results of this study indicate that this is not the case in the HMCC program. There is no relationship between type of offense and time in program.

## Figure 18. Length of Time in Program



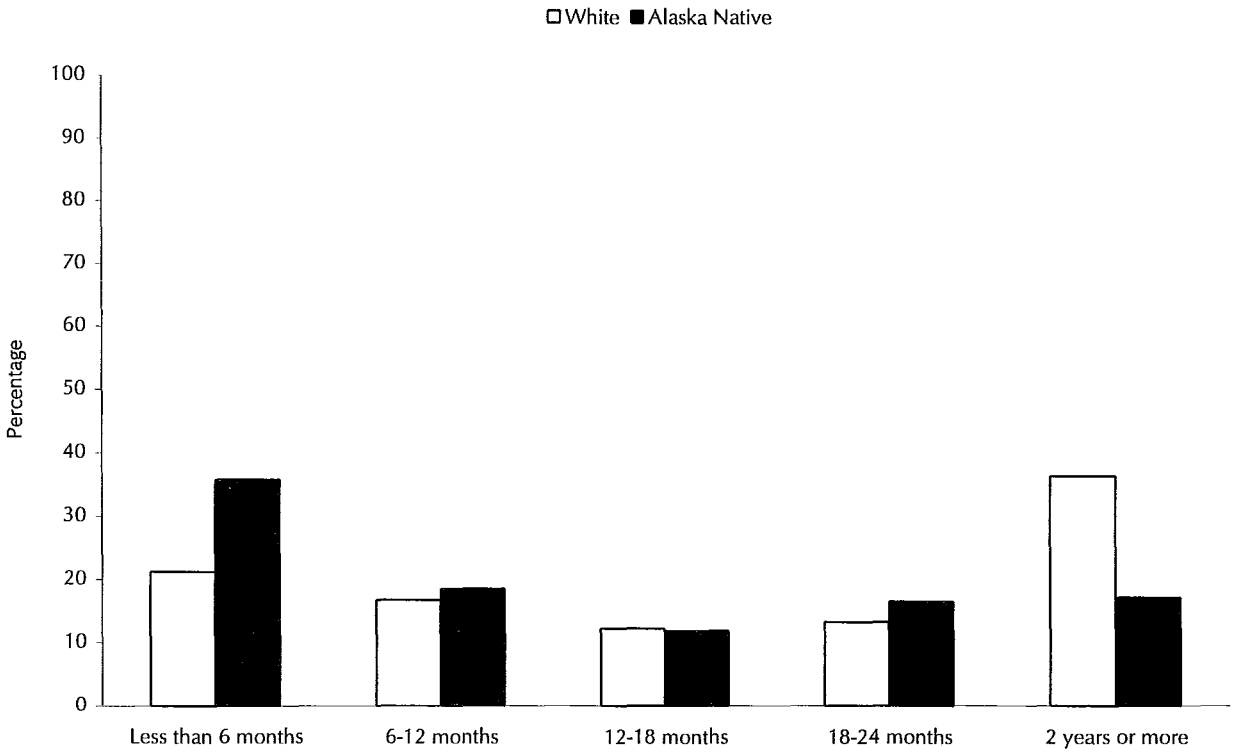

About one quarter of the participants spent less than 6 months in the program, and a nearly equal number spent 2 years or more. The average was about 17 months. The figure shows how the earlier stage of treatment functions as a second level of screening to sort out those who are not ready to actively participate in treatment after having a trial of treatment.

**Table 18. Length of Time in Program**

| | N | % |
|---|---|---|
| Less than 6 months | 112 | 27.3 % |
| 6-12 months | 74 | 18.0 |
| 12-18 months | 46 | 11.2 |
| 18-24 months | 61 | 14.8 |
| 2 years or more | 109 | 26.5 |
| Missing | 9 | 2.2 |
| **Total** | **411** | |

## Figure 19. Length of Time in Program by Race

*Whites and Alaska Natives only.*




Alaska Natives spent less time in the program than whites. A greater percentage of whites remained in for two years or longer. The relationship is statistically significant.

## Table 19. Length of Time in Program by Race

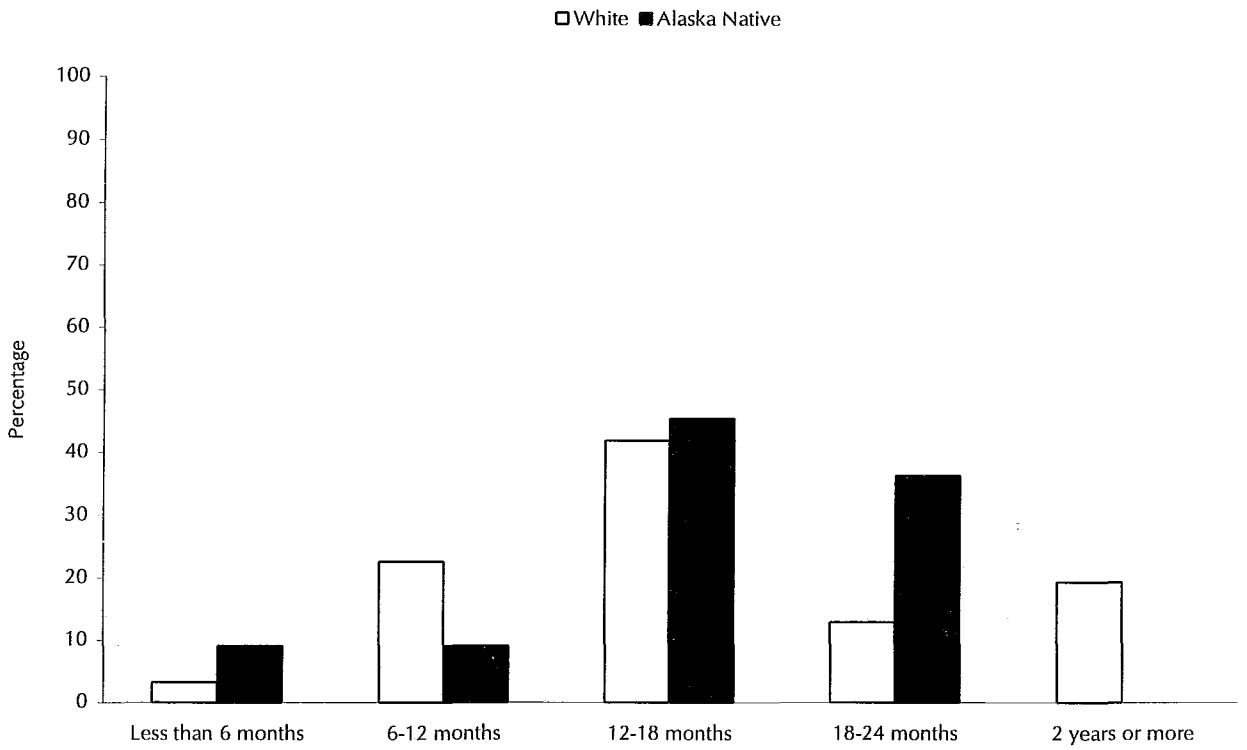
*Whites and Alaska Natives only.*

| | White | | Alaska Native | |
|---|---|---|---|---|
| | N | % | N | % |
| Less than 6 months | 43 | 21.2 % | 54 | 35.8 % |
| 6-12 months | 34 | 16.7 | 28 | 18.5 |
| 12-18 months | 25 | 12.3 | 18 | 11.9 |
| 18-24 months | 27 | 13.3 | 25 | 16.6 |
| 2 years or more | 74 | 36.5 | 26 | 17.2 |
| **Total** | **203** | | **151** | |

*Length of time in program was missing for 1 white and 5 Alaska Native participants, who are excluded from this table.*

## Figure 20. Beginning Treatment: Number of Months

*Whites and Alaska Natives only.*




When only the Beginning stage of treatment is considered, among those who completed the stage, there is no significant difference in the length of time it took the Alaska Native offenders compared to the white offenders. This finding is based on a limited number of cases because the information was not available in most of the files.

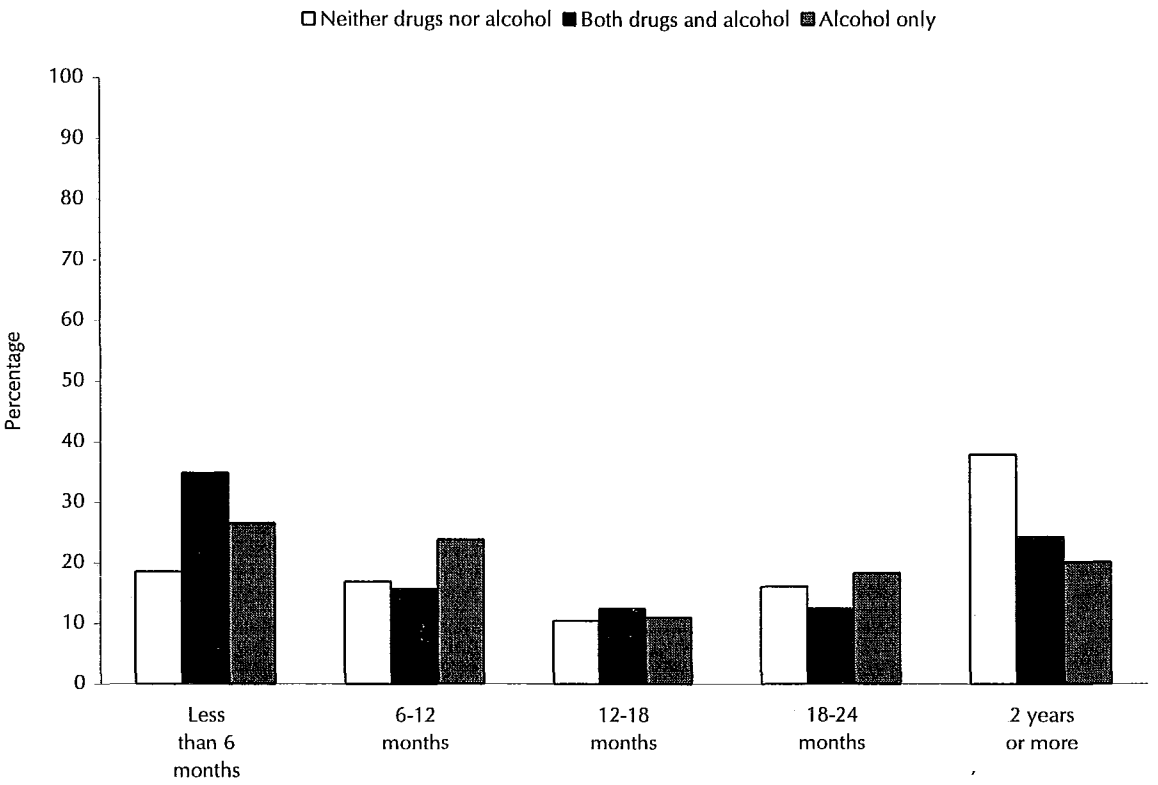
### Table 20. Beginning Treatment: Number of Months

*Whites and Alaska Natives only.*

| | White | | Alaska Native | |
|---|---|---|---|---|
| | N | % | N | % |
| Less than 6 months | 1 | 3.2 % | 1 | 9.1 % |
| 6-12 months | 7 | 22.6 | 1 | 9.1 |
| 12-18 months | 13 | 41.9 | 5 | 45.5 |
| 18-24 months | 4 | 12.9 | 4 | 36.4 |
| 2 years or more | 6 | 19.4 | 0 | 0.0 |
| **Total** | **31** | | **11** | |

## Figure 21. Length of Time in Program by Substance Abuse History

*"Drugs only" and "Substance abuse - type unknown" excluded*




Those with a history of both alcohol and drug abuse left the program sooner than those who had no history of substance abuse.

### Table 21. Length of Time in Program by Substance Abuse History

*"Drugs only" and "Substance abuse - type unknown" excluded*

| | Neither drugs nor alcohol | | Both drugs and alcohol | | Alcohol only | |
|---|---|---|---|---|---|---|
| | N | % | N | % | N | % |
| Less than 6 months | 23 | 18.5 % | 53 | 34.9 % | 29 | 26.6 % |
| 6-12 months | 21 | 16.9 | 24 | 15.8 | 26 | 23.9 |
| 12-18 months | 13 | 10.5 | 19 | 12.5 | 12 | 11.0 |
| 18-24 months | 20 | 16.1 | 19 | 12.5 | 20 | 18.3 |
| 2 years or more | 47 | 37.9 | 37 | 24.3 | 22 | 20.2 |
| **Total** | **124** | | **152** | | **109** | |

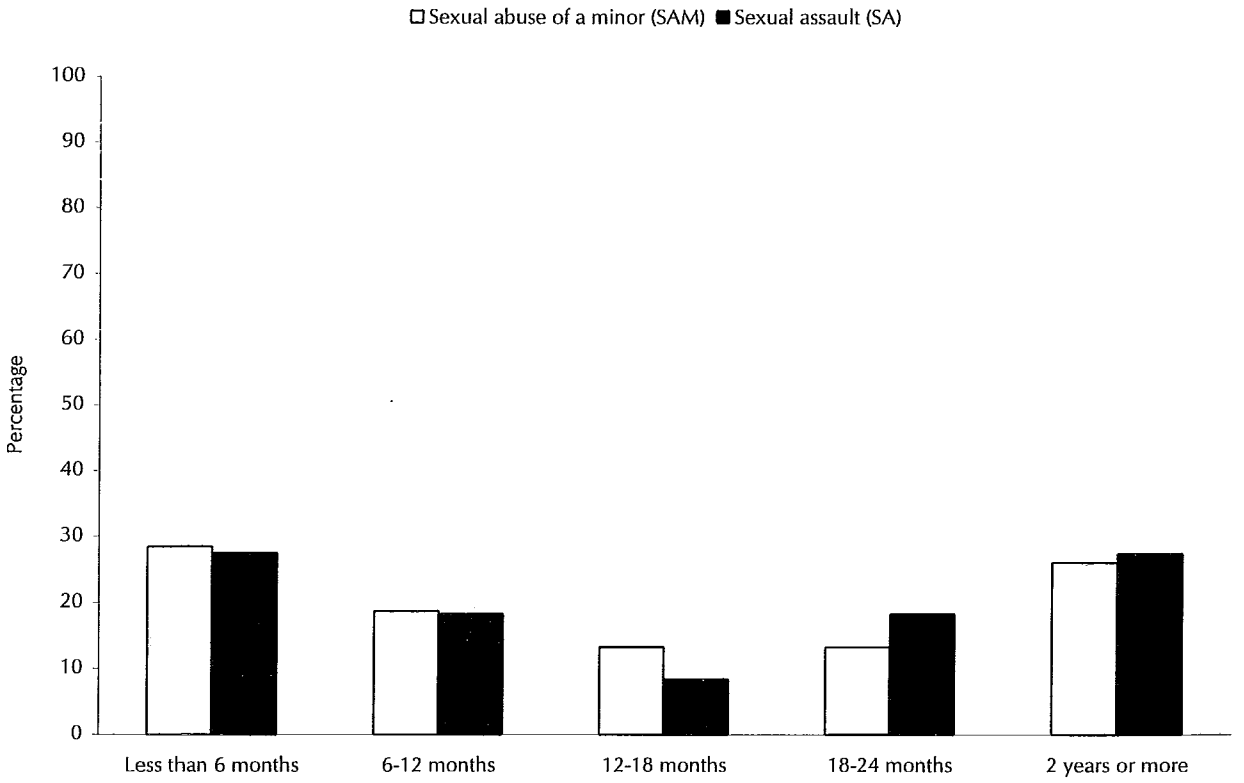
*A significant but weak relationship.*

*In 15 cases the substance abuse history was either "drugs only" (N=9) or "substance abuse - type unknown" (N=6).*

*Length of time in program was missing for 9 participants, who are excluded from this table.*

## Figure 22. Length of Time in Program by Major Offense Category

*Whites and Alaska Natives only: SAM and SA offenders only.*




There is no relationship between type of sexual offense and time spent in the program.

## Table 22. Length of Time in Program by Major Offense Category

*Whites and Alaska Natives only: SAM and SA offenders only.*

| | Sexual abuse of a minor (SAM) | | Sexual assault (SA) | |
|---|---|---|---|---|
| | N | % | N | % |
| Less than 6 months | 73 | 28.5 % | 36 | 27.5 % |
| 6-12 months | 48 | 18.8 | 24 | 18.3 |
| 12-18 months | 34 | 13.3 | 11 | 8.4 |
| 18-24 months | 34 | 13.3 | 24 | 18.3 |
| 2 years or more | 67 | 26.2 | 36 | 27.5 |
| **Total** | **256** | | **131** | |

*Length of time in program was missing for 7 SAM and SA participants, who are excluded from this table.*

*Correction to paragraph 2 (per Errata page)*: Although the actual number of Native sex offenders who left the program during the Beginning stage is greater during the Langdon period than during the Current period, the percentage of Natives leaving during the Beginning stage is actually greater during the Current period.



## 2. Treatment Stage

Treatment variables related to Treatment Stage are presented in Figures 23 through 29.

**Summary of Treatment Stage Results**

Almost 60% of the offenders were discharged from the program either during or just after completing Beginning stage (see discussion of program outcome, p. 6). Those with longer sentences tended to advance further either because they had the time needed to further themselves and/or because the longer sentences were a motivation to strive for parole. The type of offense did not seem to affect the level of attainment in program. SA offenders were roughly equivalent in stage achieved. This finding is encouraging since most sex offender programs in the United States regard the SA offender as a poor candidate for treatment in general. The HMCC program appears to deal more effectively with SA offenders than many other programs.

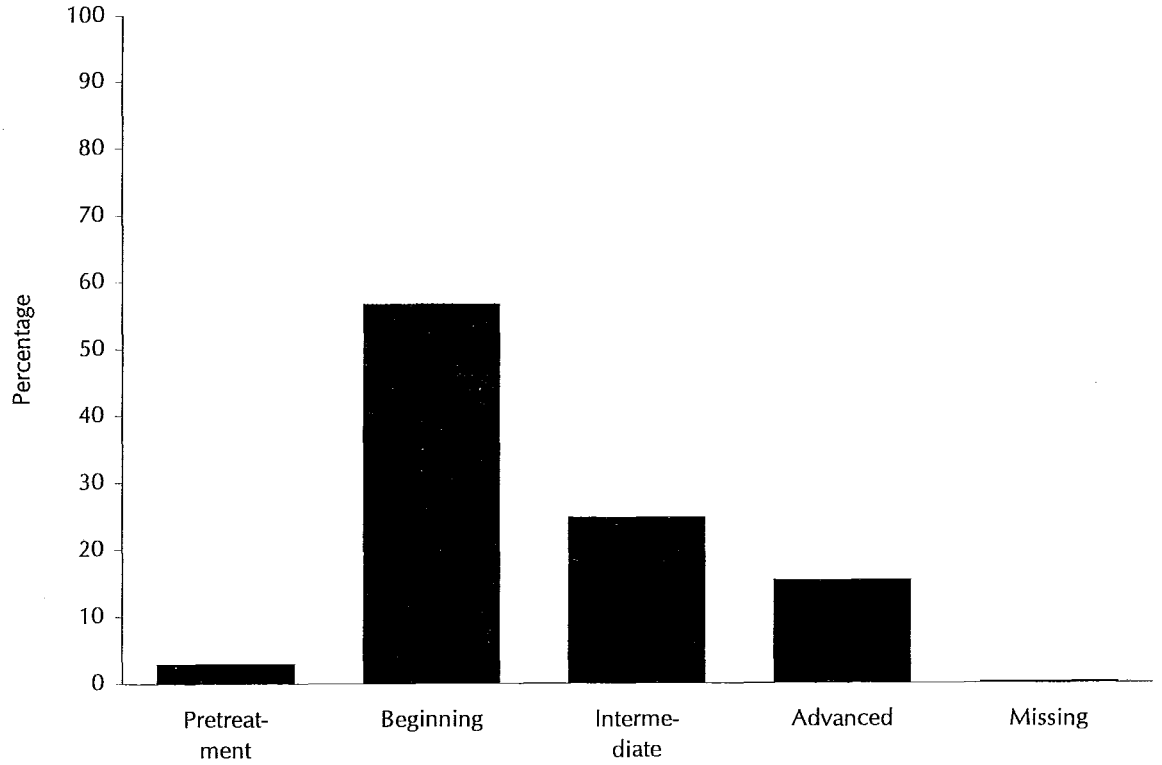
~~Alaska Native offenders tend to leave the program earlier while a greater percentage of Caucasians achieved the advanced stage. As noted above a large percentage of Natives left the program in the first 6 months. Comparing the Langdon period with the current period, it appears that more Native offenders left program from the beginning stage during the Langdon period.~~ There were no differences between periods for whites.

Offenders who had no history of substance abuse tended to advance further in the program. On the other hand a history of both alcohol and drug abuse tended to be related to less advancement. This data is consistent with the length of stay data and once again seems to support the clinical observation that those offenders who have a serious substance abuse history tend to be poorer candidates for the program. There are probably a number of reasons for this including a tendency towards impulsivity, a desire for immediate gratification, and poor stress tolerance. These are traits which interfere with the work needing to be done in more advanced programming.

Finally, it seems that those with more formal education progressed further in program. This may be related to the fact that Relapse Prevention is a highly cognitive therapy and requires skills which are taught and strengthened during formal education. There are reading and writing assignments in the program which are extremely important to the treatment process. Those with more education have an easier time with the discipline required to complete the assignments. The very fact that an individual achieved higher grades in formal education is diagnostic of important qualities which are involved in success at difficult tasks of any nature. These include concentration, discipline, rational thinking skills, achievement drive, an interest in learning, persistence and so forth. However, the level of formal education cannot totally account for progress in treatment. It is only one of numerous variables which contribute to treatment progress. Offenders with greater than High School education also leave program against treatment advice or are removed by staff for good cause. The program materials should be examined to determine reading level, as a means of insuring that they are understandable to individuals of all reading levels, especially those who learned English as a second language.

It should be pointed out that the Social Skills wing at HMCC houses offenders who have slower learning styles and require more in the way of tutoring and/or specialized assignments. Most of these individuals do not advance beyond the beginning stage. These offenders account for part of those discharged in beginning phase, however, an exact percentage is currently undetermined because there is no indicator of placement in the Social Skills wing in the older cases in the database.

## Figure 23. Treatment Stage at Discharge

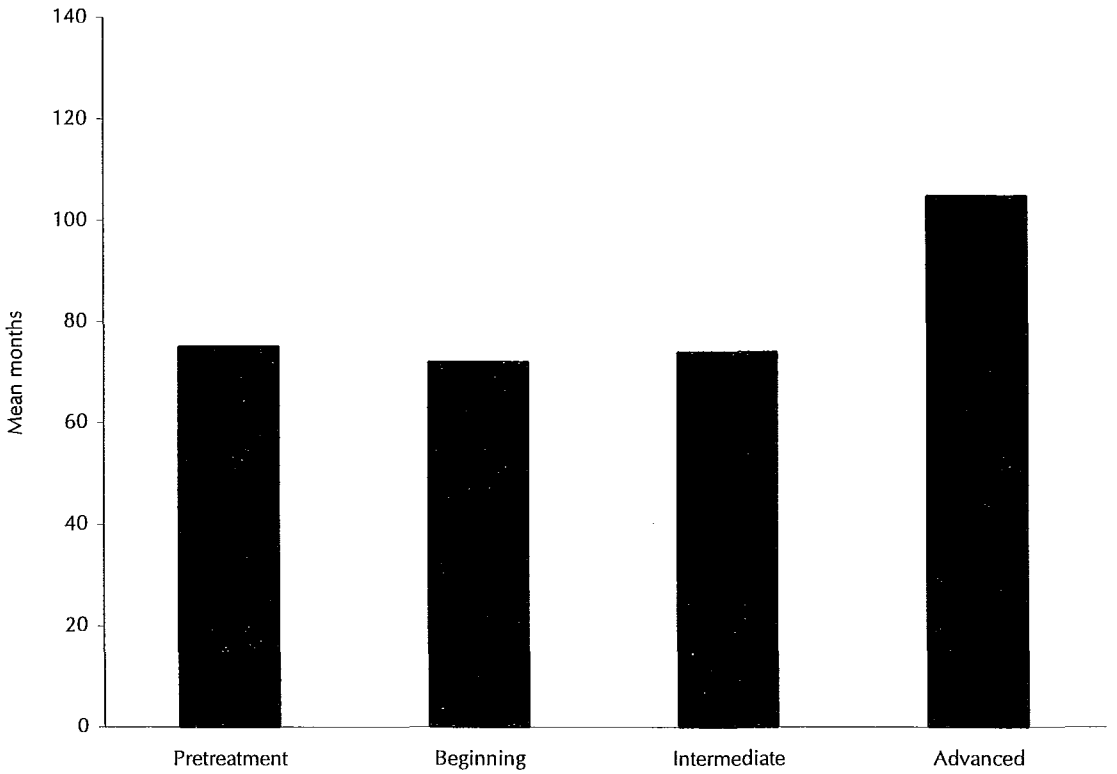



The greatest number of inmates were discharged from the progam (58.4%) either during or just after completion of the beginning stage.

**Table 23. Treatment Stage at Discharge**

| | N | % |
|---|---|---|
| Pretreatment | 12 | 2.9 % |
| Beginning | 233 | 56.7 |
| Intermediate | 102 | 24.8 |
| Advanced | 63 | 15.3 |
| Missing | 1 | 0.2 |
| **Total** | **411** | |

## Figure 24. Treatment Stage at Discharge by Mean Sentence Length




Longer sentence lengths allow time needed for the advanced stage of treatment. The longer sentences may also motivate offenders to strive for early release by parole.

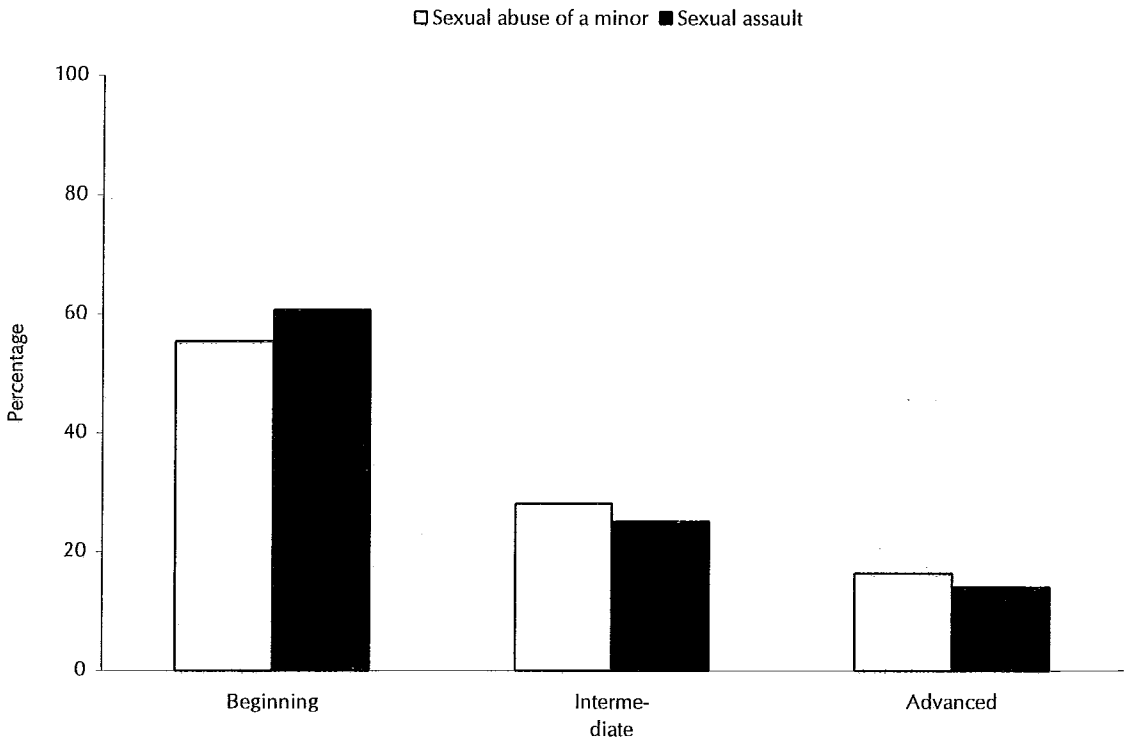
**Table 24. Treatment Stage at Discharge by Mean Sentence Length**

| | N | mean months |
|---|---|---|
| Pretreatment | 12 | 75 months |
| Beginning | 233 | 72 |
| Intermediate | 102 | 74 |
| Advanced | 63 | 105 * |
| **Total** | **410** | |

** A statistically significant increase.*
*One individual for whom data was missing is excluded from this table.*

## Figure 25. Treatment Stage at Discharge by Major Instant Offense Category

*SAM and SA offenders only; pretreatment stage exluded.*




Sexual abuse of a minor (SAM) offenders and sexual assault (SA) offenders were roughly equivalent in stage at discharge. The program appears to deal more effectively with rapists (SA offenders) than most programs. Rapists, as a group, are regarded as being more aggressive and less amenable to treatment.

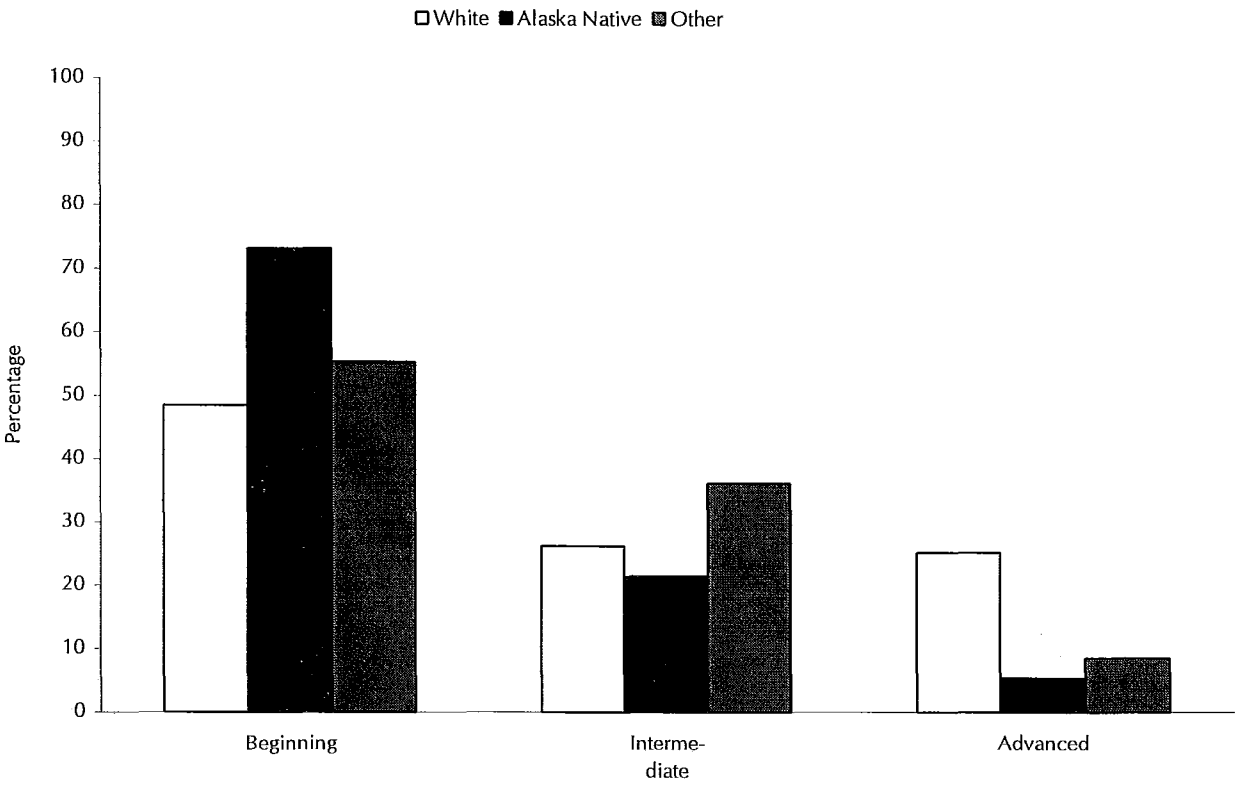
### Table 25. Treatment State at Discharge by Major Instant Offense Category

*SAM and SA offenders only; pretreatment stage exluded.*

| | **Sexual abuse of a minor** | | **Sexual assault** | |
|---|---|---|---|---|
| | **N** | **%** | **N** | **%** |
| Beginning | 71 | 55.5 | 155 | 60.8 |
| Intermediate | 36 | 28.1 | 64 | 25.1 |
| Advanced | 21 | 16.4 | 36 | 14.1 |
| **Total** | **128** | | **255** | |

## Figure 26. Treatment Stage at Discharge by Race

*Pretreatment stage exluded.*




Although participants of all races were most likely to be discharged from the program during the beginning stage, a larger percentage of whites remained in the program through the advanced stage.

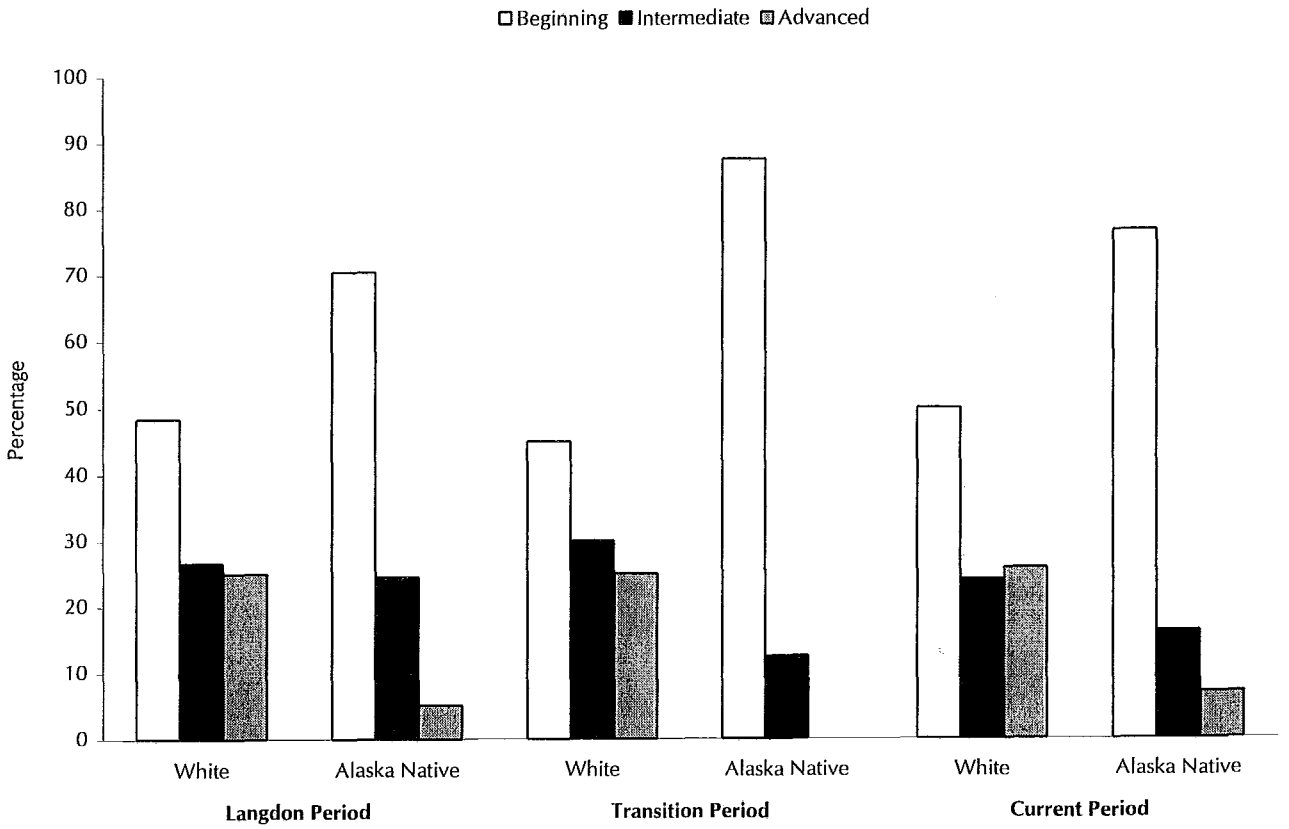
## Table 26. Treatment Stage at Discharge by Race

*Pretreatment stage exluded.*

| | White | | Alaska Native | | Other | |
|---|---|---|---|---|---|---|
| | N | % | N | % | N | % |
| Beginning | 98 | 48.5 | 109 | 73.2 | 26 | 55.3 |
| Intermediate | 53 | 26.2 | 32 | 21.5 | 17 | 36.2 |
| Advanced | 51 | 25.2 | 8 | 5.4 | 4 | 8.5 |
| **Total** | **202** | | **149** | | **47** | |

## Figure 27. Treatment Stage at Discharge by Race for Each Treatment Provider Period

*Whites and Alaska Natives only.*




There appears to be little difference between the Langdon and current periods with respect to whites. ~~However, in the Langdon period more Natives left during the beginning period of the program~~. The transition period has too few cases to make meaningful comparisons. Overall, there were too few cases to make statistical judgments.

*Correction (per Errata page):* Although the actual number of Native sex offenders who left the program during the Beginning stage is greater during the Langdon period than during the Current period, the percentage of Natives leaving during the Beginning stage is actually greater during the Current period.

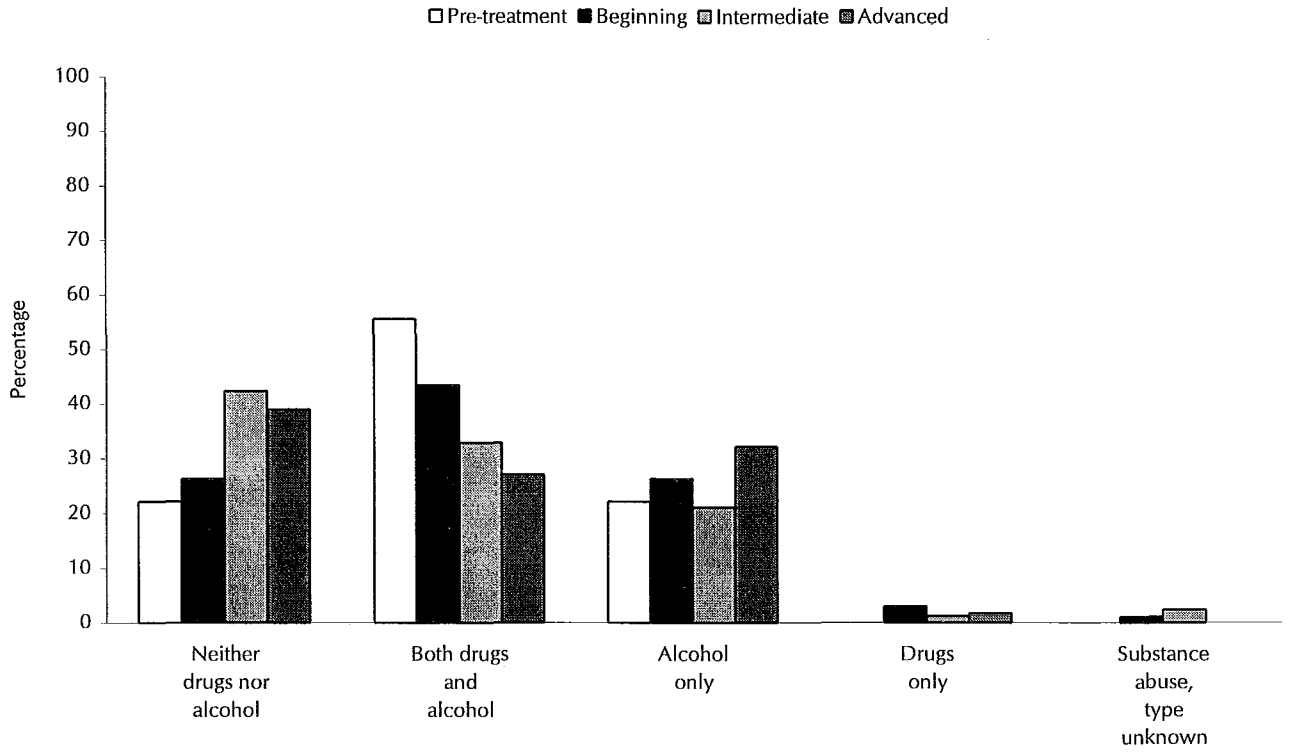
## Table 27. Treatment Stage at Discharge by Race for Each Treatment Provider Period

*Row percentages. Whites and Alaska Natives only.*

| | Beginning | | Intermediate | | Advanced | | |
|---|---|---|---|---|---|---|---|
| | N | % | N | % | N | % | Total |
| **Landgon period** | | | | | | | |
| White | 60 | 48.4 % | 33 | 26.6 % | 31 | 25.0 % | **124** |
| Alaska Native | 69 | 70.4 | 24 | 24.5 | 5 | 5.1 | **98** |
| **Total** | **129** | | **57** | | **36** | | **222** |
| **Transition period** | | | | | | | |
| White | 9 | 45.0 % | 6 | 30.0 % | 5 | 25.0 % | **20** |
| Alaska Native | 7 | 87.5 | 1 | 12.5 | 0 | 0.0 | **8** |
| **Total** | **16** | | **7** | | **5** | | **28** |
| **Current period** | | | | | | | |
| White | 29 | 50.0 % | 14 | 24.1 % | 15 | 25.9 % | **58** |
| Alaska Native | 33 | 76.7 | 7 | 16.3 | 3 | 7.0 | **43** |
| **Total** | **62** | | **21** | | **18** | | **101** |

## Figure 28. Substance Abuse History by Treatment Stage at Discharge

*Whites and Alaska Natives only.*




Treatment stage is not as sensitive a measure as length of stay; nevertheless, a substance abuse-free history is related to further advancement in the program.

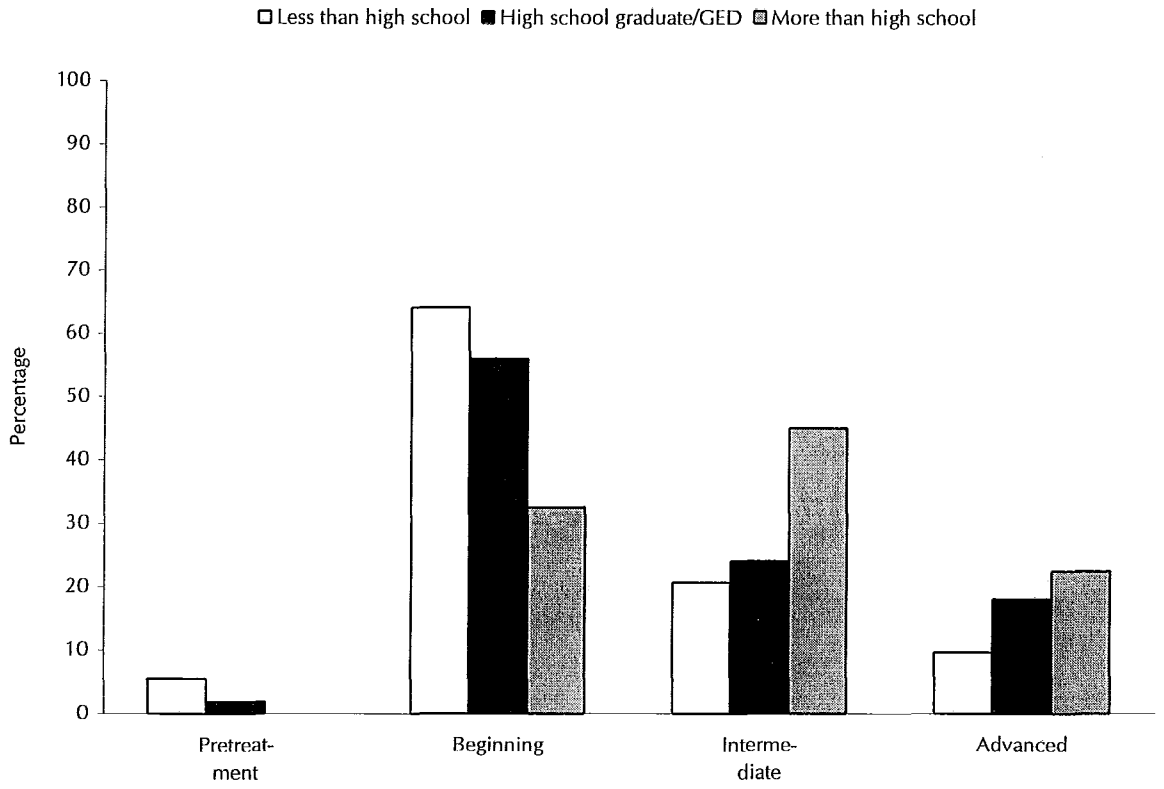
### Table 28. Substance Abuse History by Treatment Stage at Discharge

*Whites and Alaska Natives only.*

| | Pre-treatment | | Beginning | | Intermediate | | Advanced | |
|---|---|---|---|---|---|---|---|---|
| | N | % | N | % | N | % | N | % |
| Neither drugs nor alcohol | 2 | 22.2 % | 54 | 26.3 % | 36 | 42.4 % | 23 | 39.0 % |
| Both drugs and alcohol | 5 | 55.6 | 89 | 43.4 | 28 | 32.9 | 16 | 27.1 |
| Alcohol only | 2 | 22.2 | 54 | 26.3 | 18 | 21.2 | 19 | 32.2 |
| Drugs only | 0 | 0.0 | 6 | 2.9 | 1 | 1.2 | 1 | 1.7 |
| Substance abuse, type unknown | 0 | 0.0 | 2 | 1.0 | 2 | 2.4 | 0 | 0.0 |
| **Total** | **9** | | **205** | | **85** | | **59** | |

*Substance abuse status was unknown for two participants who were discharged from the program during the beginning period; they are excluded from this table.*

## Figure 29. Treatment Stage at Discharge by Education




It appears that those with more education progressed further in the program. This was a statistically significant, but weak, relationship.

### Table 29. Treatment State at Discharge by Education

| | Less than high school | | High school graduate/GED | | More than high school | |
|---|---|---|---|---|---|---|
| | N | % | N | % | N | % |
| Pretreatment | 8 | 5.5 % | 4 | 1.9 % | 0 | 0.0 % |
| Beginning | 93 | 64.1 | 121 | 56.0 | 13 | 32.5 |
| Intermediate | 30 | 20.7 | 52 | 24.1 | 18 | 45.0 |
| Advanced | 14 | 9.7 | 39 | 18.1 | 9 | 22.5 |
| **Total** | **145** | | **216** | | **40** | |

*One individual's stage at discharge was missing and nine did not have a known educational level.*

### 3. Reason for Discharge

Treatment variables related to Reason for Discharge are presented in Figures 30 through 40.

**Summary of Findings for Reason for Discharge**

The HMCC program has a two stage screening process. During pre-treatment offenders undergo a preliminary screening to determine amenability to the treatment process. Certain fundamental characteristics are necessary for an offender to enter treatment. He must, for example, accept responsibility for his crime and admit in a substantial way to the charges of which he was convicted . He must possess the basic faculties which are required for programming. This includes adequate intellectual and language skills and an ability to control his behavior in the program setting so that he does not pose a danger to himself or others, or compromise the security of the institution. He must be capable of interacting with others in a safe and productive fashion. Offenders with limited intellectual abilities or limited skills with the English language may be placed in the Social Skills wing and receive augmented programming.

The second phase of screening is a higher standard and comes only after the offender has been placed in the program and allowed to experience a trial of treatment. The treatment process is extremely challenging and requires hard work, intensive self inspection, the ability to tolerate corrective feedback, and a willingness to choose the path of healthy living and decision making. Not all offenders who enter treatment are able or willing to meet this challenge. Results indicate that about 60% left treatment either by self-removal against treatment advice (ATA) or by removal for cause by staff. Another 30.4% continued in program until their sentences ran out. These individuals who were in varying stages of the program chose to continue programming in spite of the challenges. These are considered successes by staff. Slightly less than ten pecent (9.7%) of the sample finished all stages of the program before leaving HMCC. Although this may seem like a small percentage, it should be remembered that many programs that treat sex offenders offer only the equivalent of the HMCC beginning treatment stage. Also, as we will see in the next section treatment in any amount appears to have been beneficial.

The reasons for discharge were about the same for all races except that more Caucasians were likely to complete. As was pointed out earlier it appears that more Natives quit during the Langdon Period and more were removed during the current period. The high attrition rate for Alaska Natives is an important and troubling finding. Other findings tell us that Alaska Natives in the program were younger, more likely to abuse substances and had fewer years of formal education. We also know that these variables are related to program advancement. Controlling for these variables therefore should help us to tease out the most relevant factors related to early discharge.

As it turns out, these particular variables do not totally account for the findings. Alaska Native offenders who abuse both alcohol and drugs tend to quit ATA or are removed at a higher frequency than White offenders who abuse both alcohol and drugs. Therefore, while severe substance abuse is related to offender failure in program, it appears to have a greater effect for the Native offenders.

Offenders were divided into three age categories (29 and under, 30 to 49, and 50+) to evaluate the relationship between age and reason for discharge. There was no significant relationship between race and discharge reason in the first two age categories. Youthfulness does not appear to account for the loss of Native participants. To the contrary, there was a significant relationship in the oldest age category, with a greater than expected frequency of Native offenders in this age group leaving program. The reasons for this will need to be explored in future research.

Finally, data was examined separately for offenders with a higher than High School education. These findings indicated that a higher than expected frequency of Native offenders quit ATA or were removed when compared with White offenders of the same educational level.

Findings reported earlier in this report showed that education was related to remaining in program longer and achieving more stage advancement when looking at offenders regardless of race. It appears, however, that many offenders with advanced formal education remove themselves from program. It appears that more well-educated

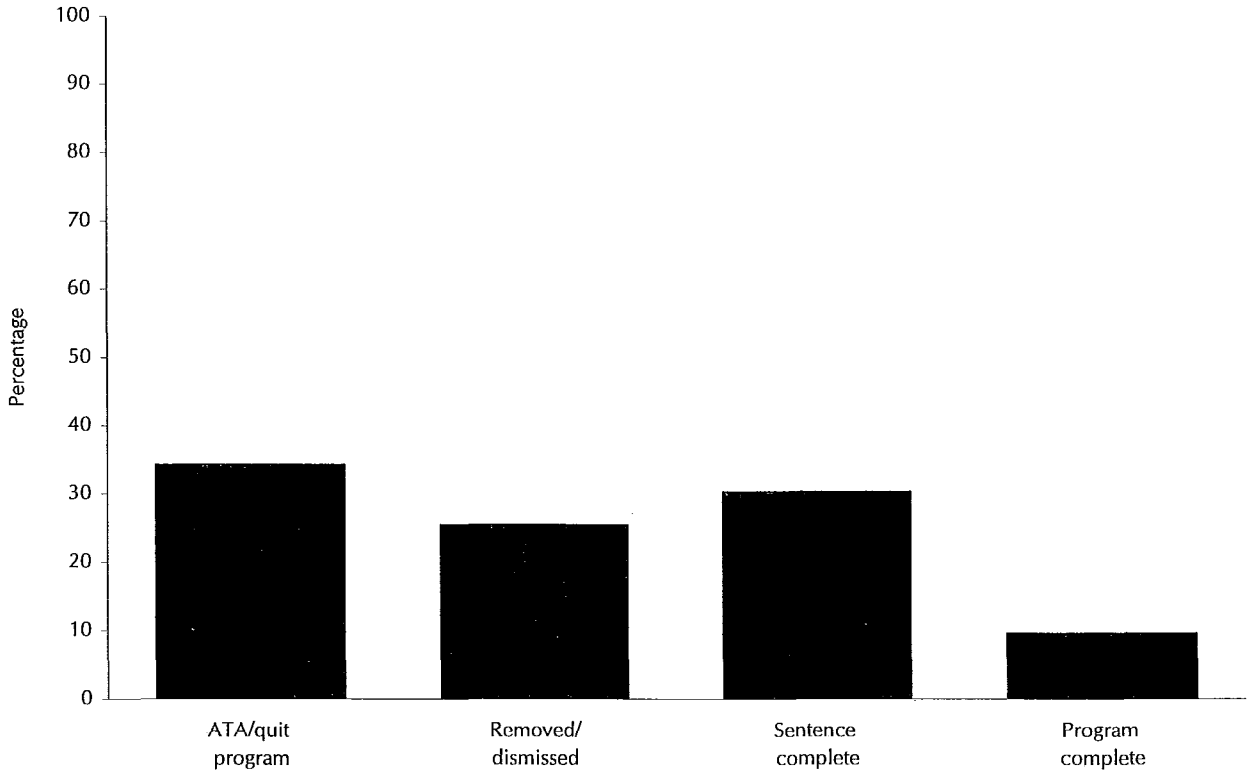
offenders left ATA during the Langdon period and more were removed by staff during the current period. This reflects the more active screening process of the current period, which is reflected over groups regardless of education. Some highly educated offenders are not amenable to treatment. While formal education is associated with program advancement, it is not the only, and certainly not the most important, predictor of success in program. Many other variables related to offender attitude and personality are likely to be more powerful predictors of success. These personality variables should be the subject of future research.

Younger subjects tend to quit program or be removed at greater frequency. Although this is a statistically significant finding, the strength of the relationship is not particularly strong.

There is no difference in the reason for discharge according to offense. The hypothesis that sexual assault (SA) offenders quit or were removed at a higher than expected frequency was not substantiated. The HMCC program appears to work well with this difficult group of offenders.

Those who completed program had significantly longer sentences. Once again this may be due simply to having enough time to complete the program but also may reflect motivation due to parole incentive.

## Figure 30. Reason for Discharge

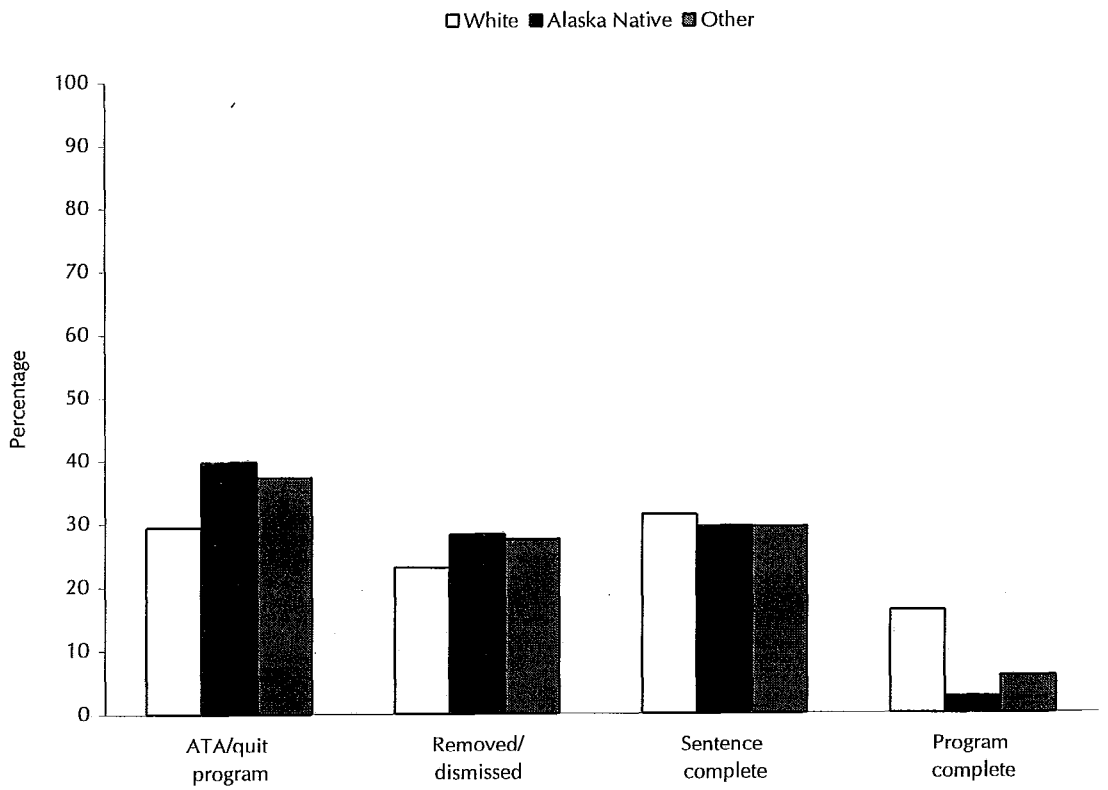



The screening process occurs at two levels. The first screening is in pretreatment, when offenders who are not amenable to treatment leave or are removed; the second level of screening is through a trial of a course of treatment. Offenders who leave early in treatment have varying degrees of active participation. 59.8 percent removed themselves or were removed by staff. 40.1 percent of offenders continued in treatment. These figures are not unusual for sex offender treatment. The screening process allows DOC to focus resources on those who are most responsive to treatment and identify those who remain at risk.

**Table 30. Reason for Discharge**

| | N | % |
|---|---|---|
| ATA/quit program | 141 | 34.3 % |
| Removed/dismissed | 105 | 25.5 |
| Sentence complete | 125 | 30.4 |
| Program complete | 40 | 9.7 |
| **Total** | **411** | |

## Figure 31. Reason for Discharge by Race



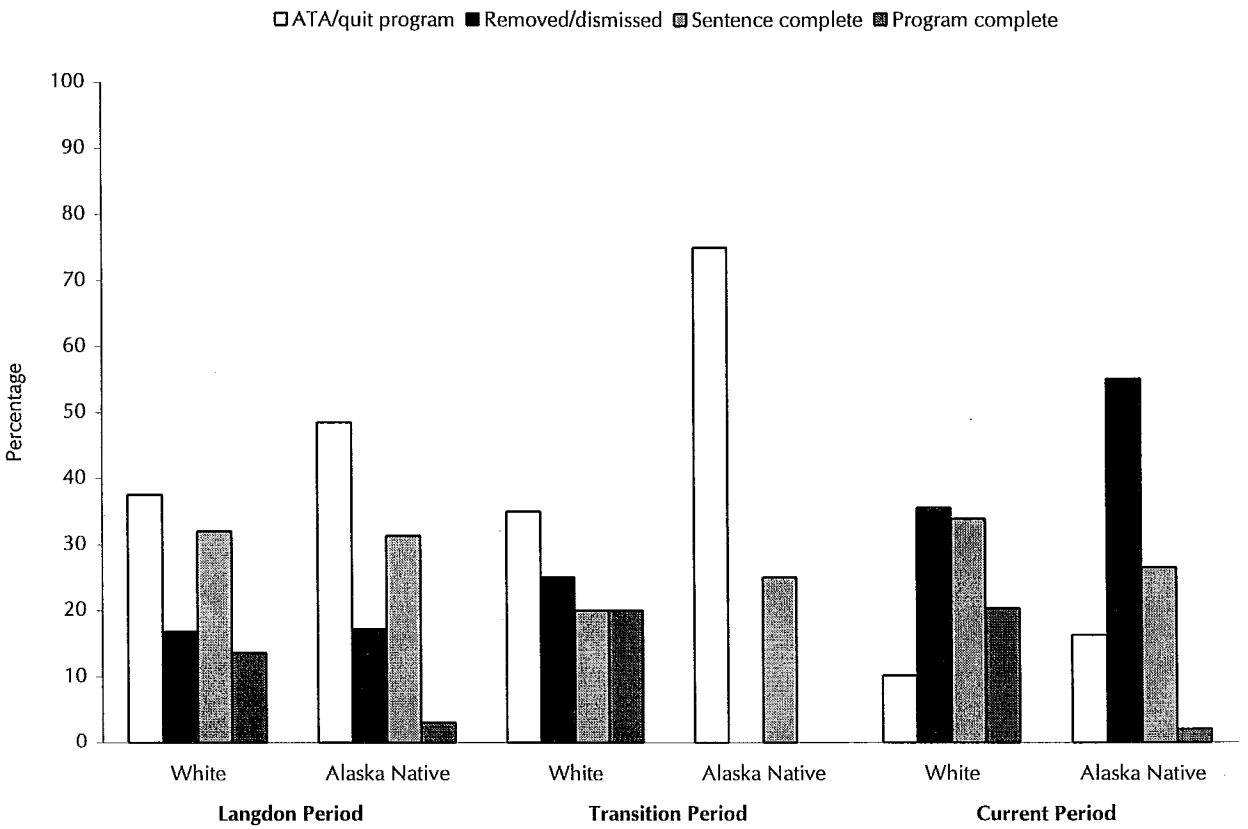

While the reason for discharge from the program was roughly the same for members of all races, whites were more likely to complete the program.

### Table 31. Reason for Discharge by Race

| | White | | Alaska Native | | Other | |
|---|---|---|---|---|---|---|
| | N | % | N | % | N | % |
| ATA/quit program | 60 | 29.4 % | 62 | 39.7 % | 19 | 37.3 % |
| Removed/dismissed | 47 | 23.0 | 44 | 28.2 | 14 | 27.5 |
| Sentence complete | 64 | 31.4 | 46 | 29.5 | 15 | 29.4 |
| Program complete | 33 | 16.2 | 4 | 2.6 | 3 | 5.9 |
| **Total** | **204** | | **156** | | **51** | |

## Figure 32. Reason for Discharge by Race for Each Treatment Provider Period

*Whites and Alaska Natives only.*




During the **Langdon period** more Alaska Natives quit the program than one might expect, and more whites completed it (statistically significant but weak relationship).

Due to the low number of Alaska Natives who left during the **transition period,** we cannot make a meaningful comparison. However, 75 percent of the Alaska Natives who left the program did so by quitting.

It appears that whites were less likely to quit or be removed during the **current period** when compared with Alaska Natives (statistically significant and moderately strong relationship).

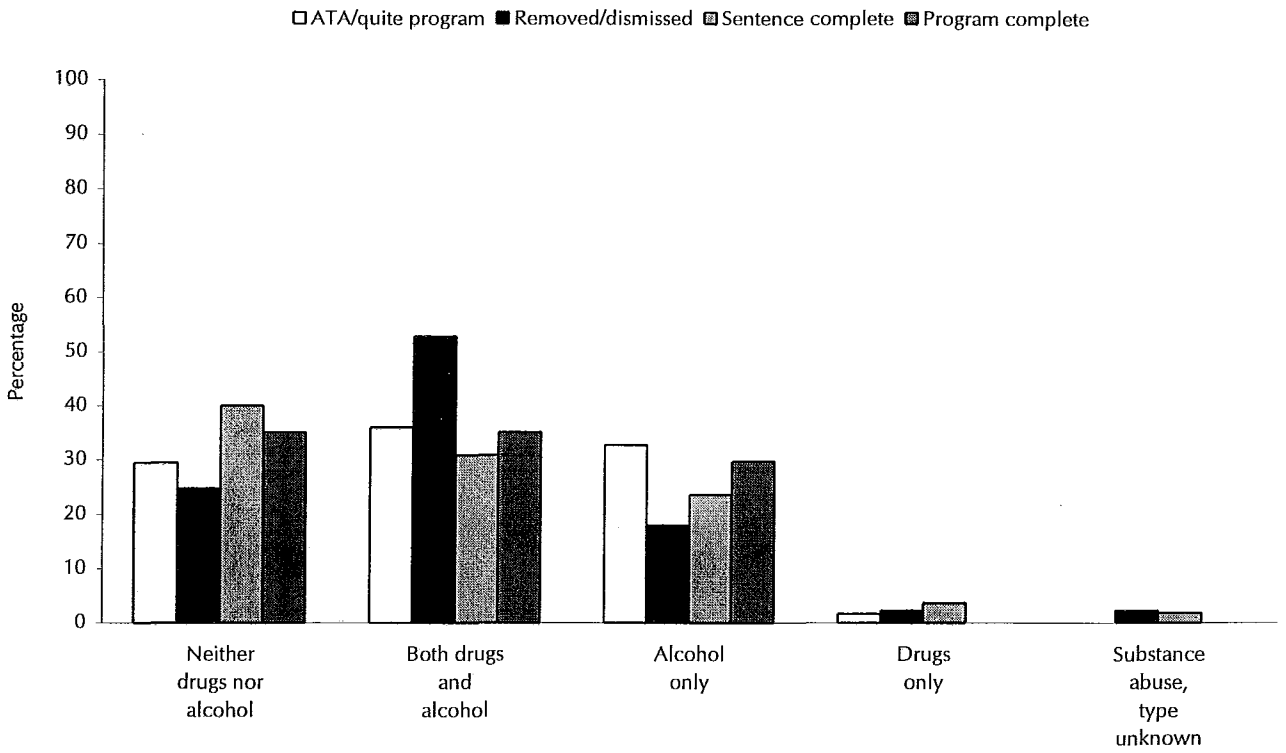
### Table 32. Reason for Discharge by Race for Each Treatment Provider Period

*Row percentages. Whites and Alaska Natives only.*

| | ATA/quit program | | Removed/dismissed | | Sentence complete | | Program complete | | |
|---|---|---|---|---|---|---|---|---|---|
| | N | % | N | % | N | % | N | % | Total |
| **Landgon period** | | | | | | | | | |
| White | 47 | 37.6 % | 21 | 16.8 % | 40 | 32.0 % | 17 | 13.6 % | **125** |
| Alaska Native | 48 | 48.5 | 17 | 17.2 | 31 | 31.3 | 3 | 3.0 | **99** |
| **Total** | **95** | | **38** | | **71** | | **20** | | **224** |
| **Transition period** | | | | | | | | | |
| White | 7 | 35.0 % | 5 | 25.0 % | 4 | 20.0 % | 4 | 20.0 % | **20** |
| Alaska Native | 6 | 75.0 | 0 | 0.0 | 2 | 25.0 | 0 | 0.0 | **8** |
| **Total** | **13** | | **5** | | **6** | | **4** | | **28** |
| **Current period** | | | | | | | | | |
| White | 6 | 10.2 % | 21 | 35.6 % | 20 | 33.9 % | 12 | 20.3 % | **59** |
| Alaska Native | 8 | 16.3 | 27 | 55.1 | 13 | 26.5 | 1 | 2.0 | **49** |
| **Total** | **14** | | **48** | | **33** | | **13** | | **108** |

## Figure 33. Reason for Discharge by Substance Abuse History

*Whites and Alaska Natives only.*




Those who use both drugs and alcohol tend to be removed and those who abuse neither drugs nor alcohol tend to complete the program or leave due to completion of sentence.

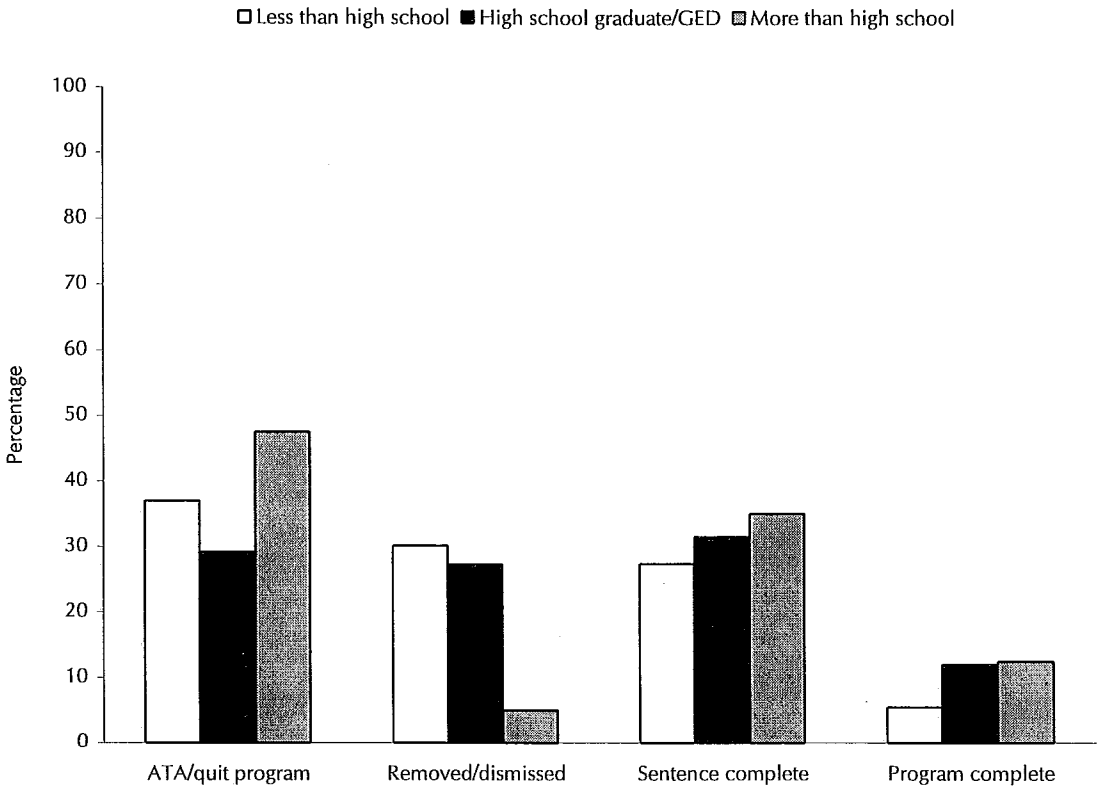
## Table 33. Reason for Discharge by Substance Abuse History

*Whites and Alaska Natives only.*

| | ATA/quite program | | Removed/dismissed | | Sentence complete | | Program complete | |
|---|---|---|---|---|---|---|---|---|
| | N | % | N | % | N | % | N | % |
| Neither drugs nor alcohol | 36 | 29.5 % | 22 | 24.7 % | 44 | 40.0 % | 13 | 35.1 % |
| Both drugs and alcohol | 44 | 36.1 | 47 | 52.8 | 34 | 30.9 | 13 | 35.1 |
| Alcohol only | 40 | 32.8 | 16 | 18.0 | 26 | 23.6 | 11 | 29.7 |
| Drugs only | 2 | 1.6 | 2 | 2.2 | 4 | 3.6 | 0 | 0.0 |
| Substance abuse, type unknown | 0 | 0.0 | 2 | 2.2 | 2 | 1.8 | 0 | 0.0 |
| **Total** | **122** | | **89** | | **110** | | **37** | |

*Substance abuse status was unknown for two participants who were removed/dismissed from the program; they are excluded from this table.*

## Figure 34. Reason for Discharge by Education



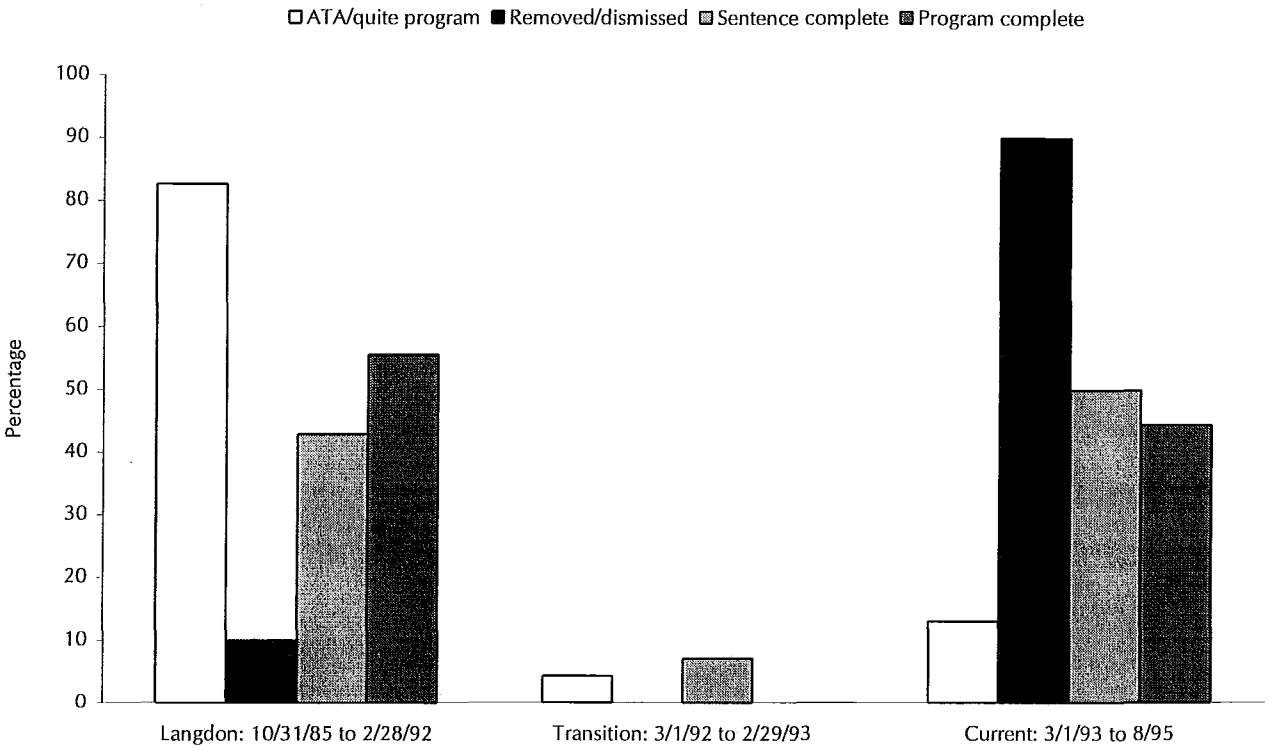

Nearly 48 percent of those with more than a high school education quit the program, while only 5 percent of them were removed or dismissed. Only about 6 percent of those with less than a high school education completed the program.

### Table 34. Reason for Discharge by Education

| | Less than high school | | High school graduate/GED | | More than high school | |
|---|---|---|---|---|---|---|
| | N | % | N | % | N | % |
| ATA/quit program | 54 | 37.0 % | 63 | 29.2 % | 19 | 47.5 % |
| Removed/dismissed | 44 | 30.1 | 59 | 27.3 | 2 | 5.0 |
| Sentence complete | 40 | 27.4 | 68 | 31.5 | 14 | 35.0 |
| Program complete | 8 | 5.5 | 26 | 12.0 | 5 | 12.5 |
| **Total** | **146** | | **216** | | **40** | |

*Educational level was missing for 5 inmates who quit the program, 3 who completed their sentences, and 1 inmate who completed the program.*

## Figure 35. Reason for Discharge by Provider Period for Offenders with More than High School Education



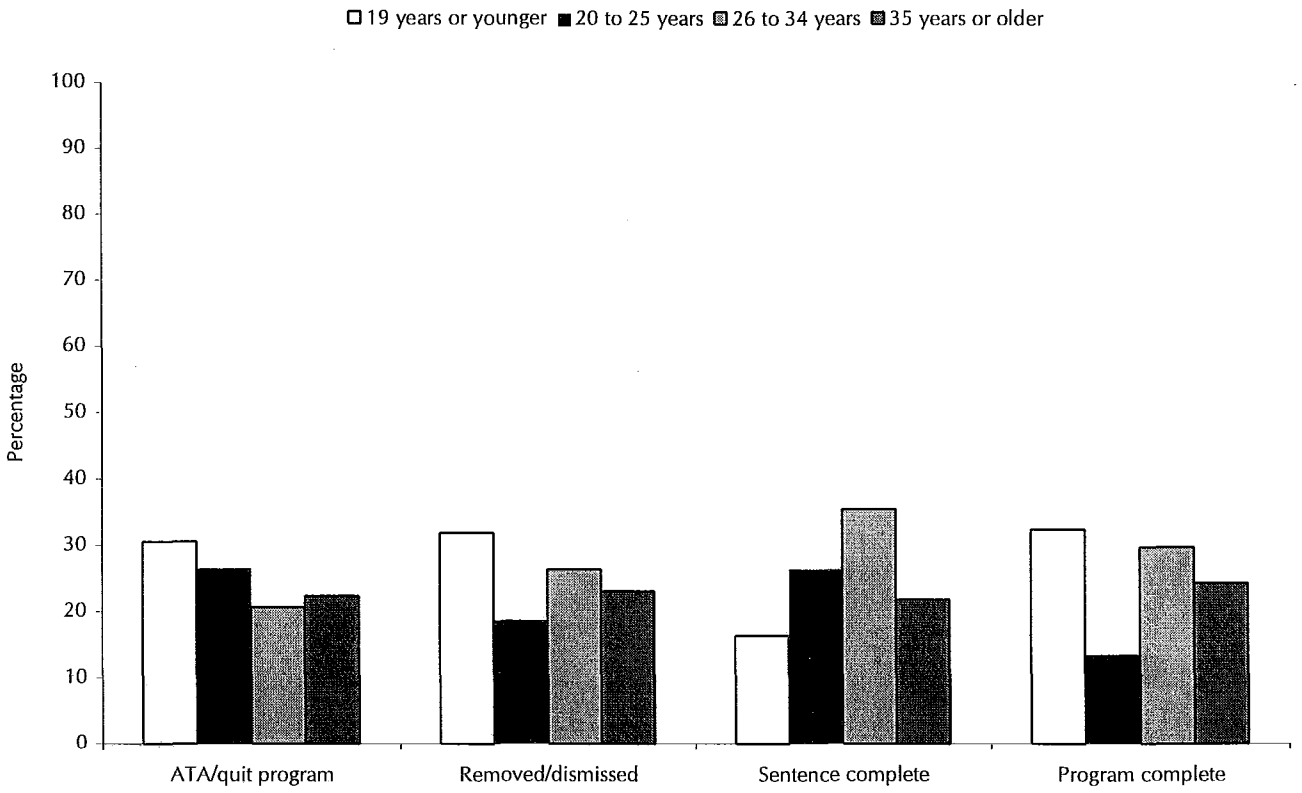

During the Langdon period, many well-educated offenders were quitting the program and some were being removed. During the current period, this trend has reversed, so that some are quitting but a larger number are being removed. This may be due to the fact that the program more actively screens out those offenders who are not amenable to treatment. Although higher levels of education are correlated with program advancement, education is not the only, and certainly not the most important, variable related to program success.

### Table 35. Reason for Discharge by Provider Period for Offenders with More than High School Education

| | ATA/quite program | | Removed/dismissed | | Sentence complete | | Program complete | |
|---|---|---|---|---|---|---|---|---|
| | N | % | N | % | N | % | N | % |
| Langdon: 10/31/85 to 2/28/92 | 19 | 82.6 % | 2 | 10.0 % | 12 | 42.9 % | 5 | 55.6 % |
| Transition: 3/1/92 to 2/29/93 | 1 | 4.3 | 0 | 0.0 | 2 | 7.1 | 0 | 0.0 |
| Current: 3/1/93 to 8/95 | 3 | 13.0 | 18 | 90.0 | 14 | 50.0 | 4 | 44.4 |
| **Total** | **23** | | **20** | | **28** | | **9** | |

## Figure 36. Age at First Known Sex Offense by Reason for Discharge from Program

*Whites and Alaska Natives only.*




Age at first sex offense does not appear related to a participant's eventual discharge from the program.

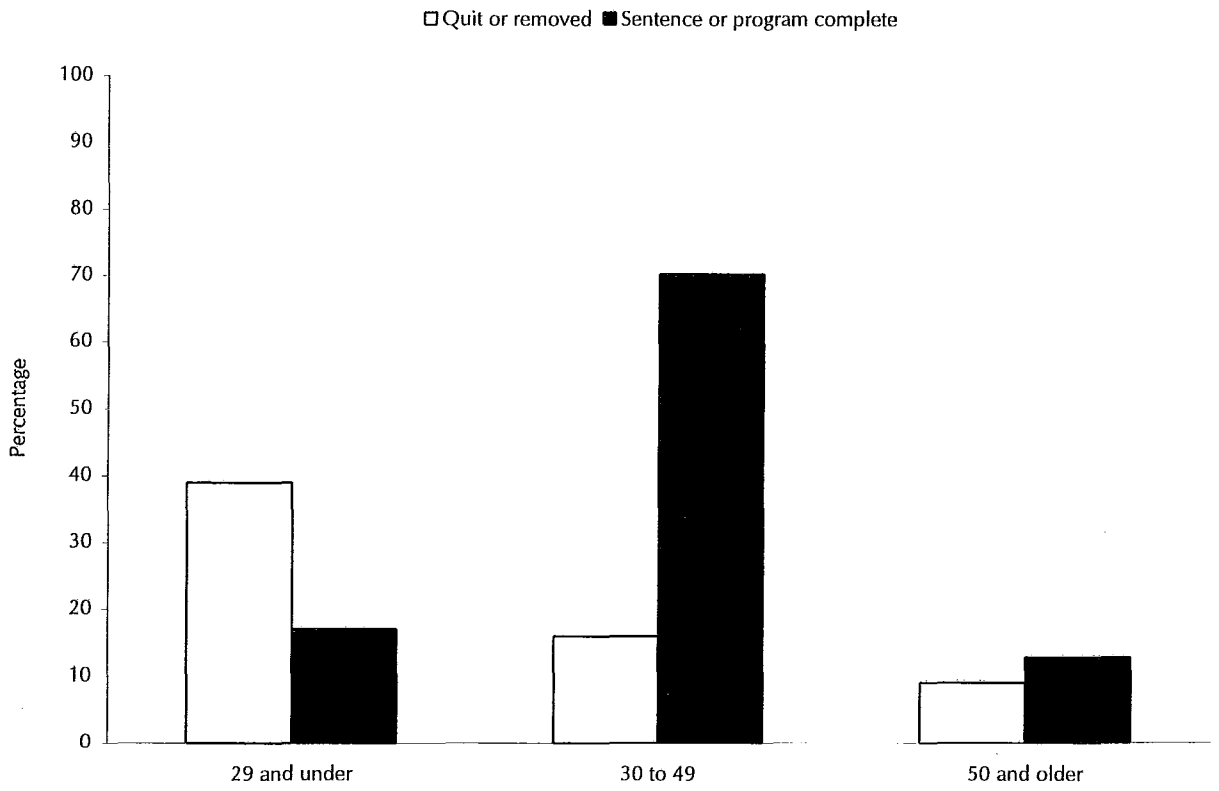
## Table 36. Age at First Known Sex Offense by Reason for Discharge from Program

*Whites and Alaska Natives only.*

| | ATA/quit program | | Removed/dismissed | | Sentence complete | | Program complete | |
|---|---|---|---|---|---|---|---|---|
| | N | % | N | % | N | % | N | % |
| 19 years or younger | 37 | 30.6 % | 29 | 31.9 % | 18 | 16.4 % | 12 | 32.4 % |
| 20 to 25 years | 32 | 26.4 | 17 | 18.7 | 29 | 26.4 | 5 | 13.5 |
| 26 to 34 years | 25 | 20.7 | 24 | 26.4 | 39 | 35.5 | 11 | 29.7 |
| 35 years or older | 27 | 22.3 | 21 | 23.1 | 24 | 21.8 | 9 | 24.3 |
| **Total** | **121** | | **91** | | **110** | | **37** | |

*The age of first sex offense was missing for one participant who quit the program; this participant is excluded from this table.*

## Figure 37. Reason for Discharge by Grouped Age




There is a significant relationship between age of offender and reason for discharge. Younger offenders tend to leave the program against treatment advice or be removed by staff at a higher than expected frequency compared to offenders in the other age groups.

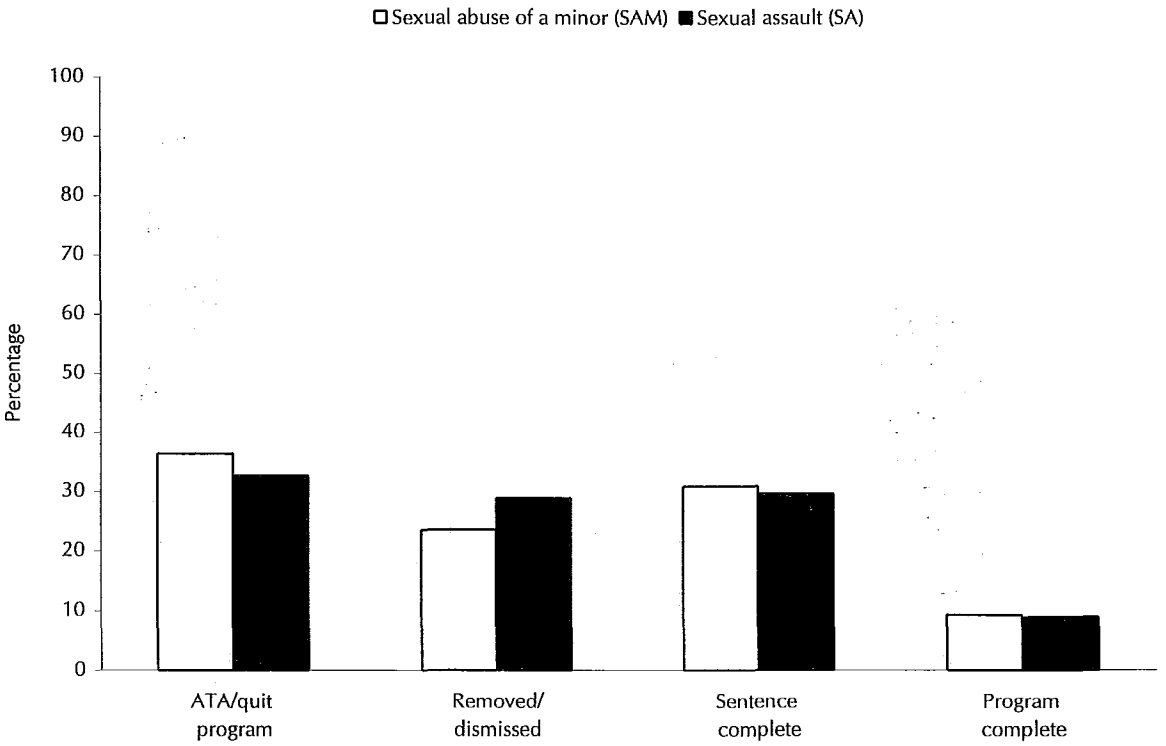
### Table 37. Reason for Discharge by Grouped Age

| | Quit or removed | | Sentence or program complete | |
|---|---|---|---|---|
| | N | % | N | % |
| 29 and under | 95 | 38.9 % | 28 | 17.1 % |
| 30 to 49 | 127 | 52.0 | 115 | 70.1 |
| 50 and older | 22 | 9.0 | 21 | 12.8 |
| **Total** | **244** | | **164** | |

*Reason for discharge was missing for three participants, who are excluded from this table.*

## Figure 38. Reason for Discharge by Major Offense Category

*SAM and SA offenders only.*



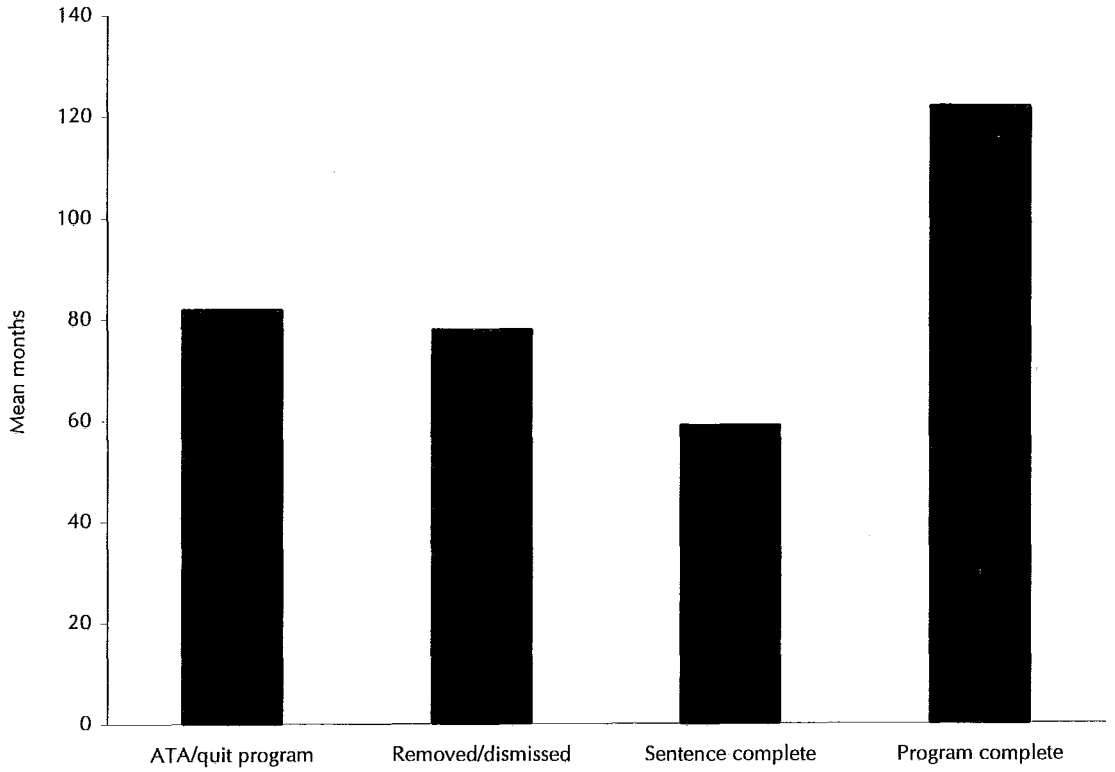

There was no difference in the reason for discharge according to offense. The hypothesis that sexual assault (SA) offenders quit or were removed at a higher rate than sexual abuse of a minor (SAM) offenders was not substantiated.

**Figure 38. Reason for Discharge by Major Offense Category**

*SAM and SA offenders only.*

| | **Sexual abuse of a minor (SAM)** | | **Sexual assault (SA)** | |
|---|---|---|---|---|
| | N | % | N | % |
| ATA/quit program | 94 | 36.3 % | 44 | 32.6 % |
| Removed/dismissed | 61 | 23.6 | 39 | 28.9 |
| Sentence complete | 80 | 30.9 | 40 | 29.6 |
| Program complete | 24 | 9.3 | 12 | 8.9 |
| **Total** | **259** | | **135** | |

## Figure 39. Reason for Discharge from Program by Mean Sentence Length



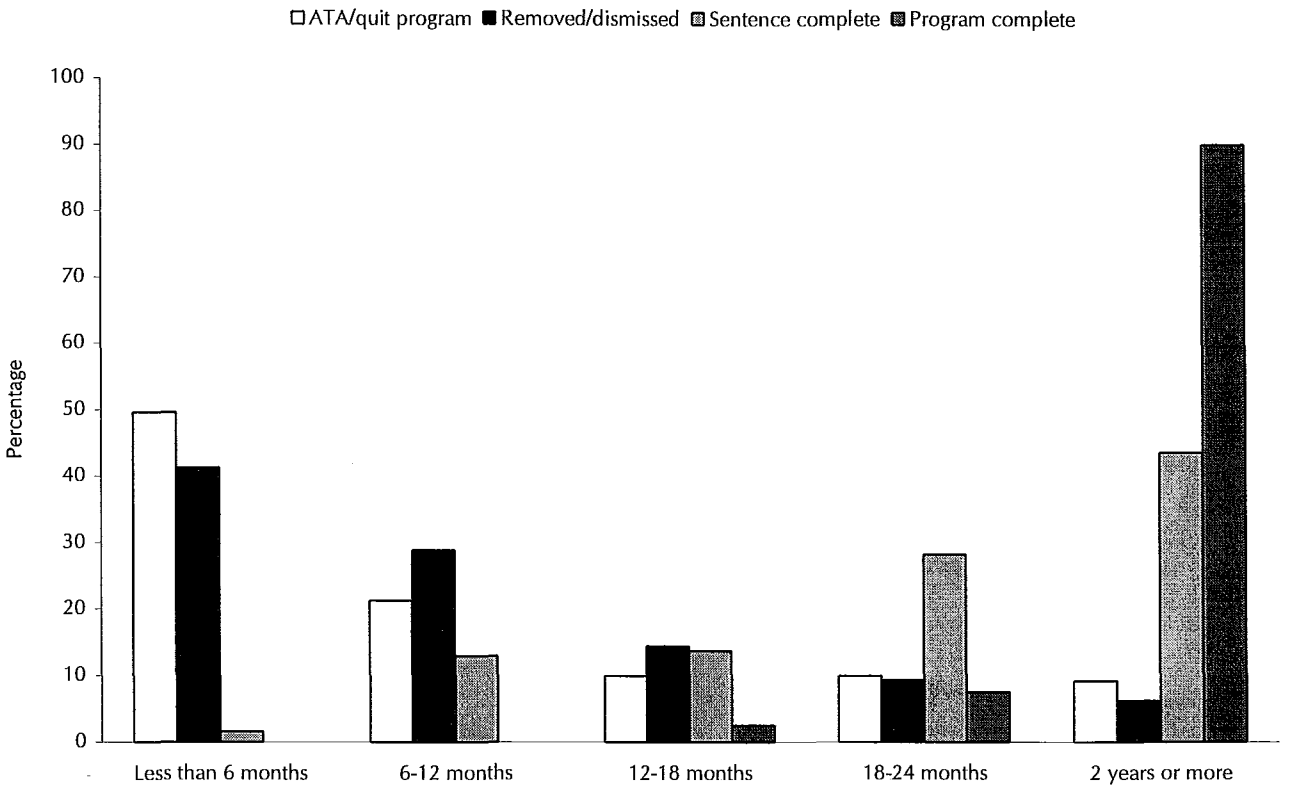

Those who completed the program had statistically longer sentences (mean = 122 months) than those whose sentences ran out while in the program (mean = 59 months).

### Table 39. Reason for Discharge from Program by Mean Sentence Length

| | N | mean months |
|---|---|---|
| ATA/quit program | 141 | 82 months |
| Removed/dismissed | 105 | 78 |
| Sentence complete | 125 | 59 |
| Program complete | 40 | 122 * |
| **Total** | **411** | |

** A statistically significant increase.*

## Figure 40. Length of Time in Program by Reason for Discharge




Those whose sentences run out and those who complete the program spend significantly more time in it than those who quit or are removed.

**Table 40. Length of Time in Program by Reason for Discharge**

| | ATA/quit program | | Removed/dismissed | | Sentence complete | | Program complete | |
|---|---|---|---|---|---|---|---|---|
| | N | % | N | % | N | % | N | % |
| Less than 6 months | 70 | 49.6 % | 40 | 41.2 % | 2 | 1.6 % | 0 | 0.0 % |
| 6-12 months | 30 | 21.3 | 28 | 28.9 | 16 | 12.9 | 0 | 0.0 |
| 12-18 months | 14 | 9.9 | 14 | 14.4 | 17 | 13.7 | 1 | 2.5 |
| 18-24 months | 14 | 9.9 | 9 | 9.3 | 35 | 28.2 | 3 | 7.5 |
| 2 years or more | 13 | 9.2 | 6 | 6.2 | 54 | 43.5 | 36 | 90.0 |
| **Total** | **141** | | **97** | | **124** | | **40** | |

*Length of time in program was missing for 9 participants, who are excluded from this table.*

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# V. Results

## C. Re-Offense Data

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## C. Re-offense Data

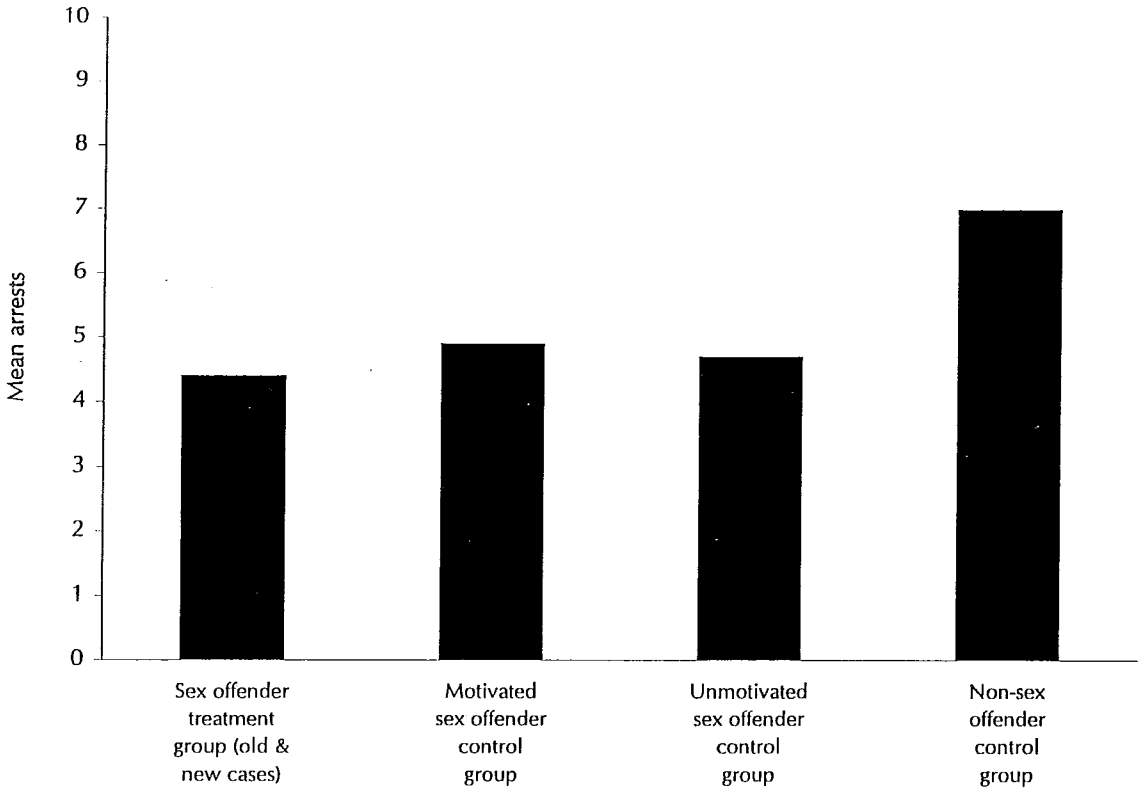
Re-offense data is presented in Figures 41 through 50.

**Summary of the Re-offense Data**

The results of the data analysis indicate that sex offenders who had any amount of sex offender treatment had the best survival rate compared to the other groups. Furthermore, there were no re-offenses among the sex offenders who completed all stages of treatment. Offenders who did not seek treatment (unmotivated controls) had the next best survival rate, followed by those who sought treatment but did not receive it (motivated controls). The difference between the motivated and unmotivated control groups was not significant and this trend may reverse itself as more data is collected. There may be other unknown differences between these groups which may account for the finding. In any case, the finding is an unexpected one and deserves further study. The treated offenders survived longer in the community without a re-offense however recidivism was defined. Even when there was a re-offense treatment seemed to prolong the survival. Both the amount of treatment and the stage of advancement are related to survival. These two ways of trying to measure treatment effect are confounded (mixed together) as stage achievement requires longer time in program. Since it takes a longer amount of time to advance in treatment, it's hard to know if the amount of time in treatment or the stage achieved is responsible for the improvement. It is probable that the same phenomenon is being looked at from slightly different angles. It is clear that survival rate is related to advancement in treatment. We get clear improvements in survival rate according to how much treatment is provided and incorporated. The more of the treatment process which the offender incorporates the more successful the result.

There was a slight tendency for SA offenders to offend more frequently and sooner than SAM offenders. This is consistent with findings from other parts of the country and the world. Stage advancement seems to be particularly important for the SA offenders. Those who achieved intermediate or advanced status survived at a much higher rate than those that achieved only beginning status. There was about a 10% increase in survival rate for SA offenders as they advanced from beginning to intermediate and from intermediate to advanced. Although the data shows a similar pattern for SAM offenders, the differences are not as striking. There are not enough cases in the sample for some of the differences between groups to reach statistical significance. However, it is important to note that most of the differences that emerge are in the direction predicted, which suggests that there may be an effect. When more cases become available for analysis, we can assume that the differences between groups are likely to reach significance. The improvement in re-offense rates appear to be robust in that it emerges consistently, even when the results are examined in slightly different ways.

## Figure 41. Total Reoffense Arrests by Major Type of Case



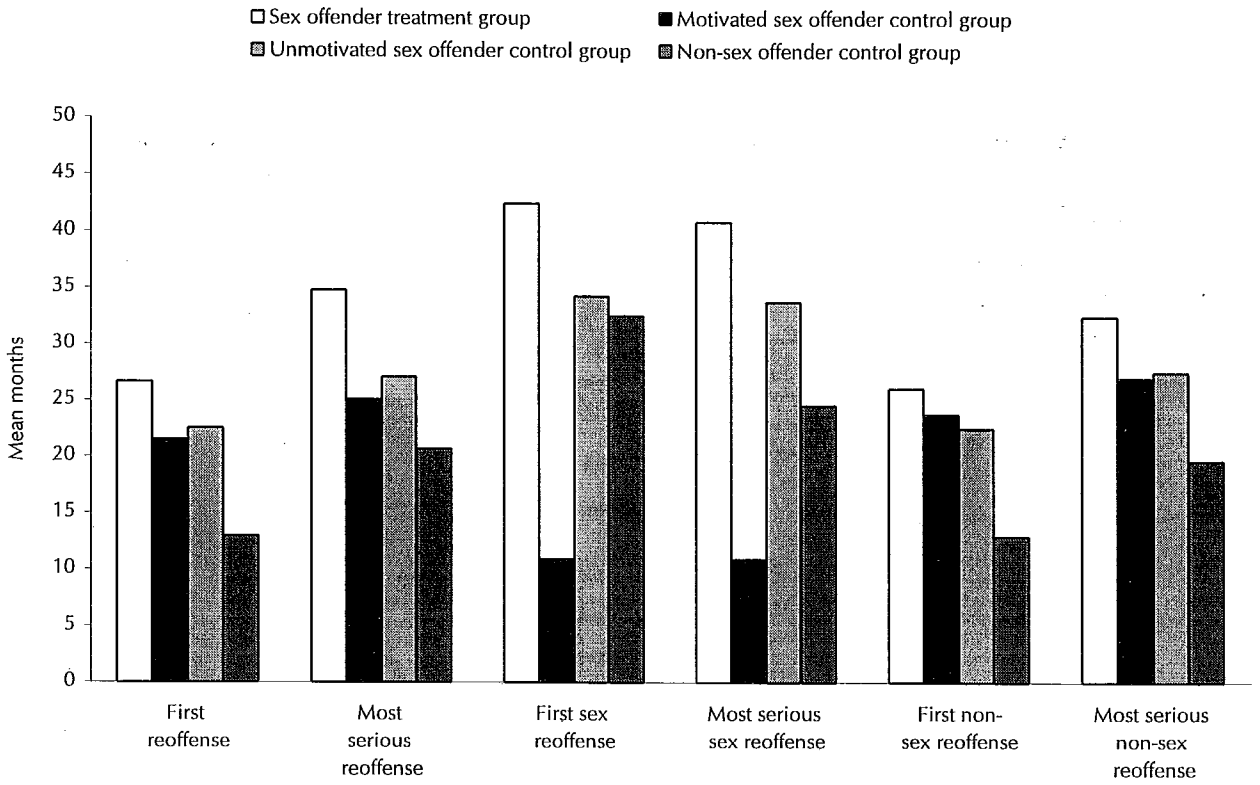

For those inmates who had at least one rearrest after release, the treated inmates had fewer rearrest charges of any kind than any other group.

### Table 41. Total Reoffense Arrests by Major Type of Case

(revised 5-14-97)

| | Number in database | Number released from prison prior to 1-1-96 | Number with at least one rearrest | Percent of released inmates rearrested | Mean number of arrests per arrested inmate |
|---|---|---|---|---|---|
| Sex offender treatment group (old & new cases) | 411 | 344 | 74 | 21.5 % | 4.4 arrests |
| Motivated sex offender control group | 74 | 71 | 32 | 45.1 | 4.9 |
| Unmotivated sex offender control group | 86 | 86 | 27 | 31.4 | 4.7 |
| Non-sex offender control group | 100 | 100 | 57 | 57.0 | 7.0 |
| **Total** | **671** | **601** | **190** | **31.6 %** | |

## Figure 42. Number of Months to Recidivism by Main Type of Group and Crime




In each measure we have for recidivism, the treated cases, if they had a rearrest, were in the community longer than the other types of cases. This tells us that even when there is a reoffense, treatment seems to prolong the period before relapse. This is shown graphically in Figure 43, which shows survival curves until first rearrest.

### Table 42. Number of Months to Recidivism by Main Type of Group and Crime

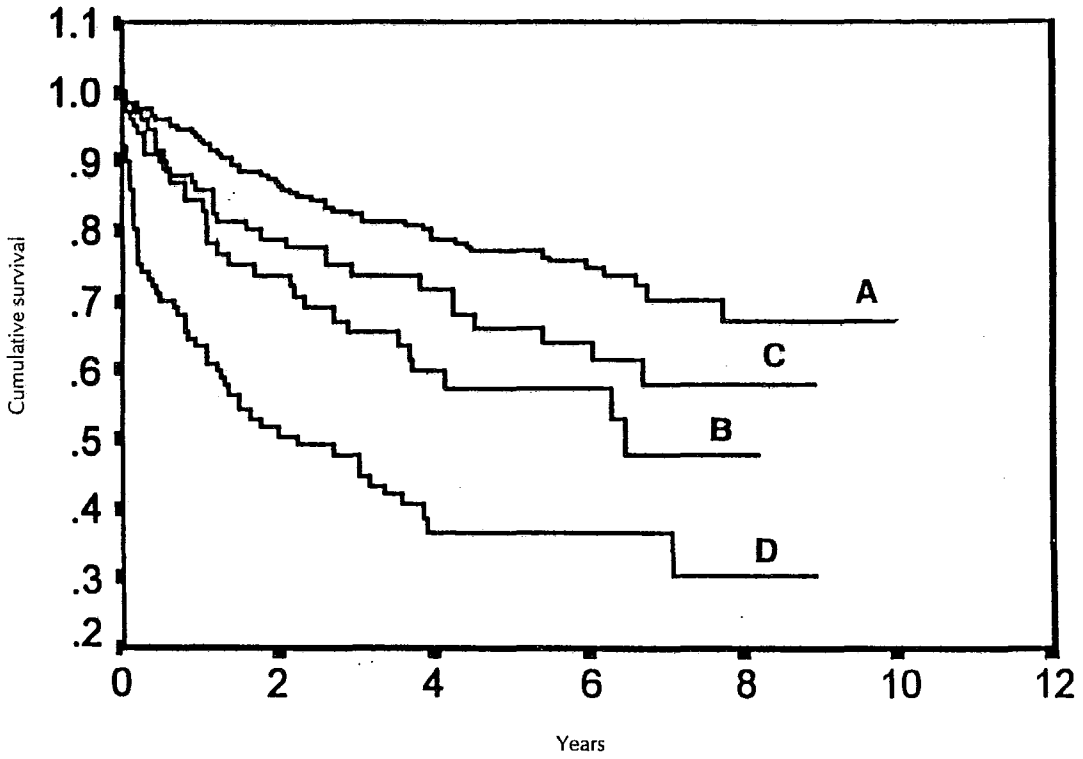
| | First reoffense (1) | | Most serious reoffense (1) | | First sex reoffense (2) | | Most serious sex reoffense (2) | | First non-sex reoffense (1) | | Most serious non-sex reoffense (1) | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | N | months | N | months | N | months | N | months | N | months | N | months |
| Sex offender treatment group | 74 | 26.7 | 74 | 34.8 | 13 | 42.4 | 12 | 40.8 | 71 | 26.1 | 71 | 32.5 |
| Motivated sex offender control group | 32 | 21.5 | 32 | 25.1 | 3 | 10.9 | 3 | 10.9 | 30 | 23.8 | 30 | 27.1 |
| Unmotivated sex offender control group | 27 | 22.5 | 27 | 27.1 | 2 | 34.3 | 2 | 33.8 | 27 | 22.5 | 27 | 27.6 |
| Non-sex offender control group | 57 | 13.0 | 57 | 20.7 | 5 | 32.6 | 5 | 24.5 | 57 | 13.0 | 57 | 19.7 |
| **Total** | **190** | | **190** | | **23** | | **22** | | **185** | | **185** | |

*1. A means test indicates a significant relationship between the type of case and months to recidivism.*

*2. Although the mean differences appear to be large, the small number of cases reduces our ability to rely on the means test to determine the statistical significance of any relationship.*

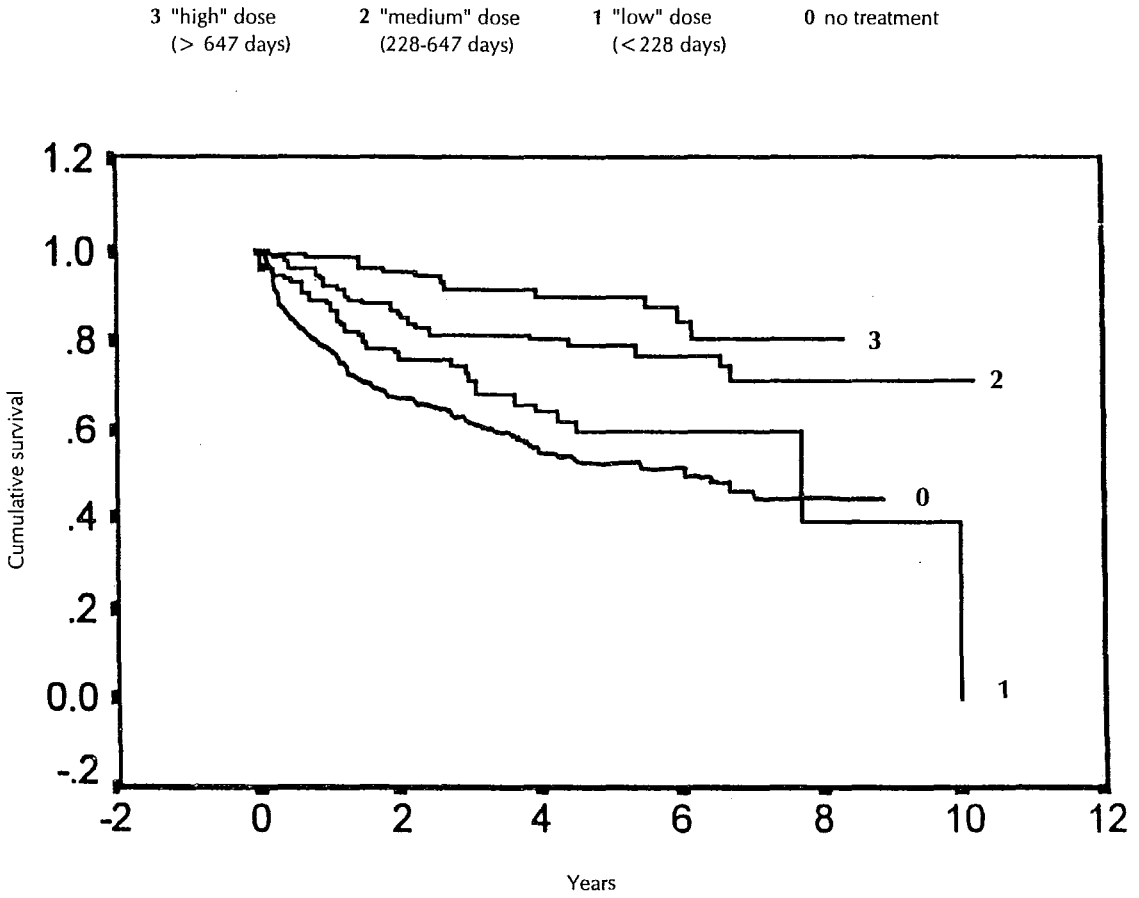
## Figure 43. Survival Functions: Years at Risk to First Rearrest

A Sex offender treatment group
B Motivated sex offender control group
C Unmotivated sex offender control group
D Non-sex offender control group



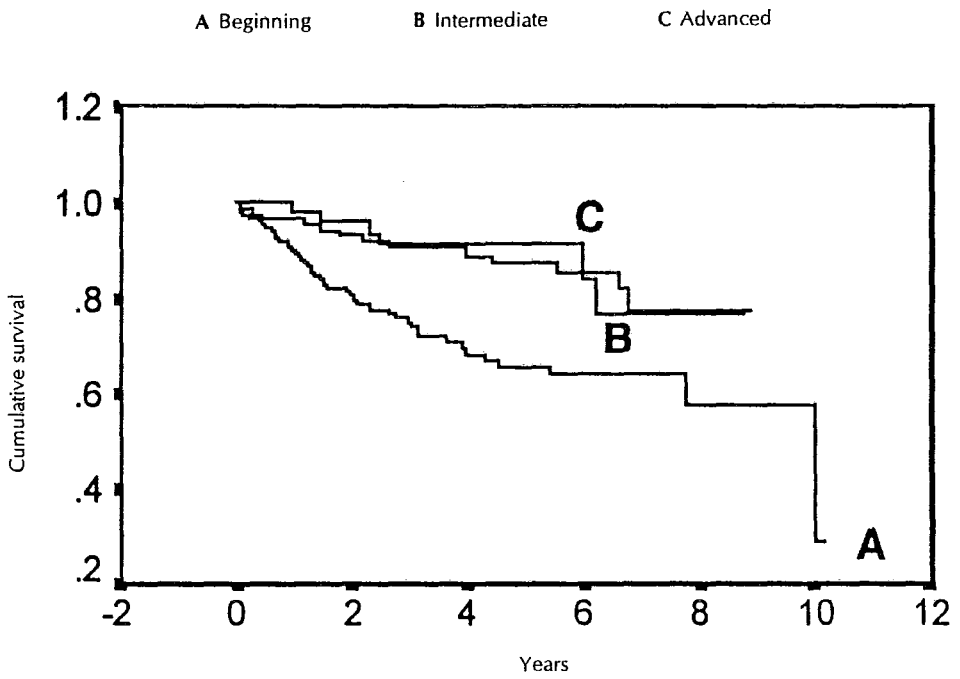

This figure shows that the treatment group has a superior survival rate compared to controls. It appears that the unmotivated control group had a slightly better survival rate than the motivated control groups. This was an unexpected finding.

## Figure 44. Survival Functions: Recidivism -- Year of First Offense



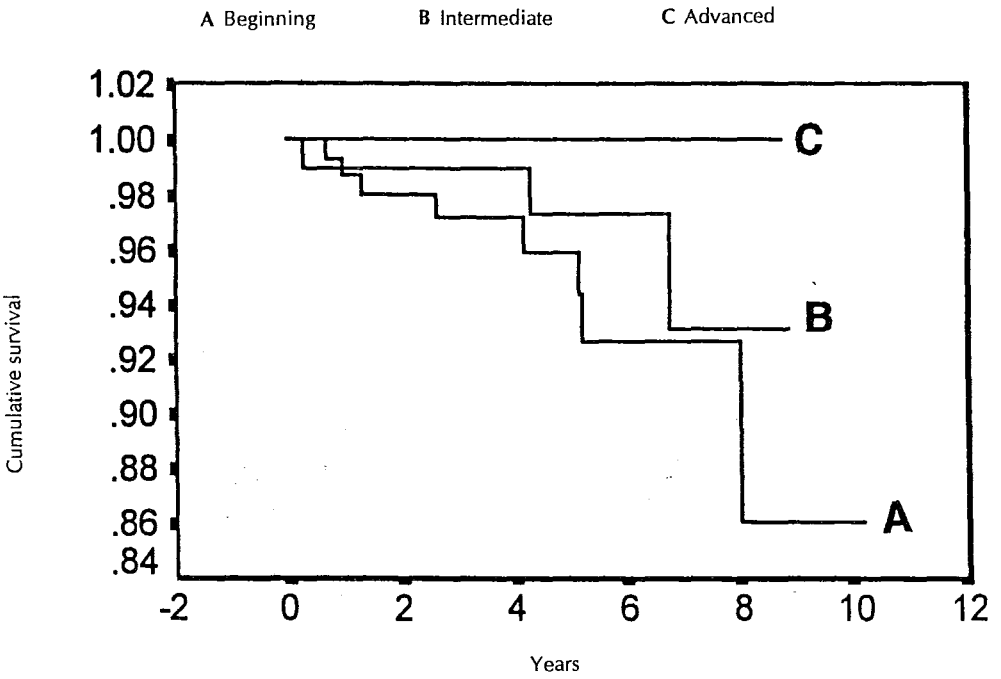

The treatment group was divided into three levels of "dose," low, medium, and high. This corresponds to the number of total days that they spent in treatment. This was calculated by dividing the total range into thirds. The groups fall out as expected, with "high dose" offenders doing the best, followed by "medium" and "low" doses. The above chart does not contain any of the "censored" cases (those offenders who had not reoffended at the time the survival curve was constructed); each group had censored cases.

## Figure 45. Survival to First Arrest by Treatment Stage at Discharge



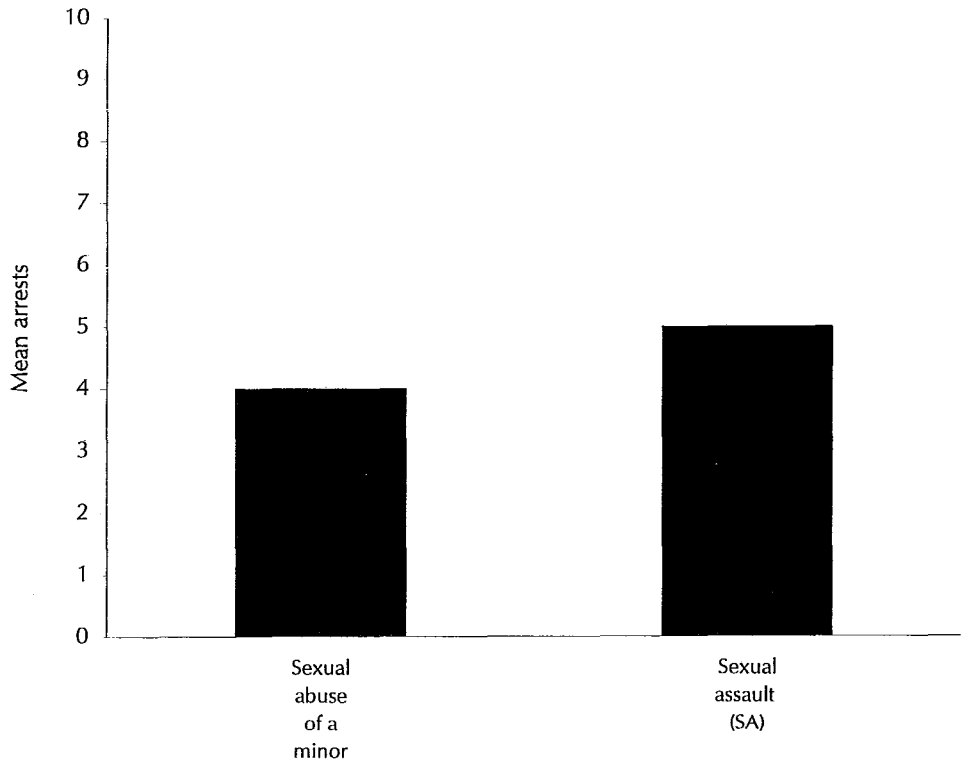

Because time in treatment does not necessarily reflect advancement, the data for the treatment group was plotted according to stage achieved. This figure shows results for first rearrest. The data is as expected, with advanced stage offenders surviving best, but the difference between advanced and intermediate stage offenders is negligible. The differences overall approach statistical significance.

## Figure 46. Survival to First Sex Offense Arrest by Treatment Stage at Discharge




The survival data for sexual reoffenses more clearly shows the relationship between advancement in stage and survival rate. There were no sexual reoffenses for offenders in the advanced stage of treatment. These differences also approached statistical significance.

## Figure 47. Total Reoffense Arrests by Offense Category

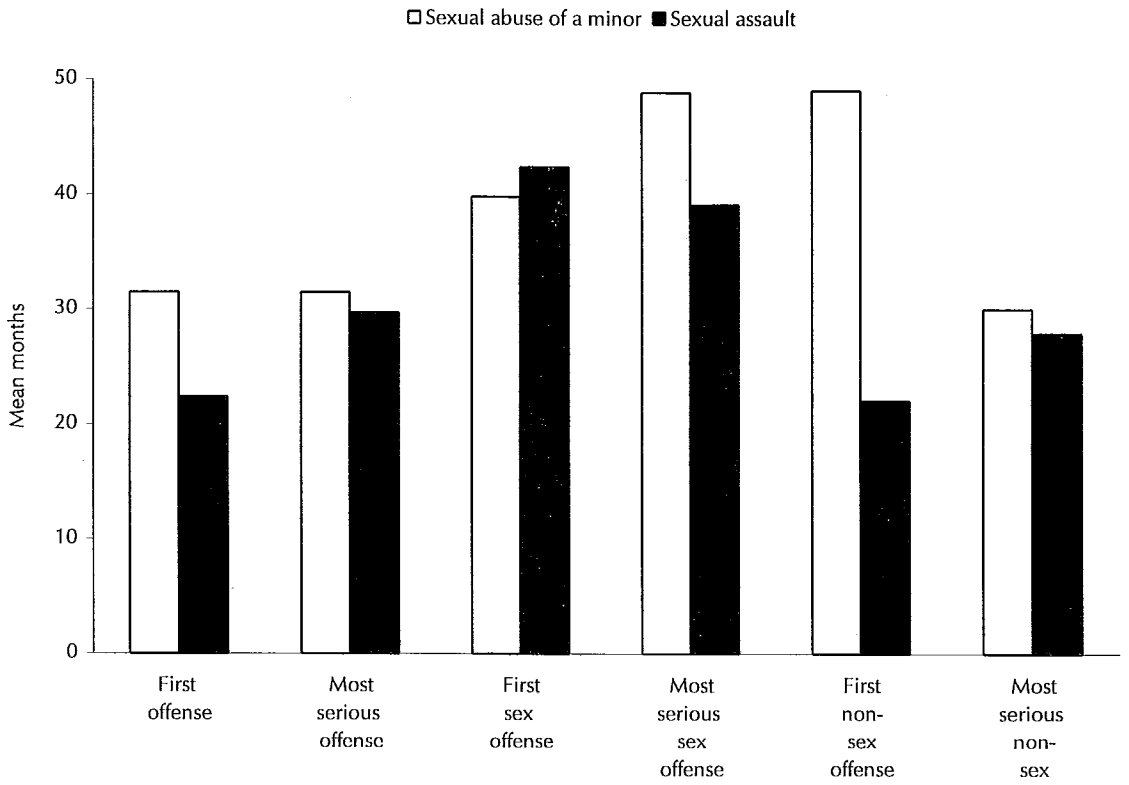



Inmates convicted of sexual assault (SA) had slightly more reoffense charges of any kind than those convicted of sexual abuse of a minor (SAM).

### Table 47. Total Reoffense Arrests by Offense Category

| | N | Mean number of arrests |
|---|---|---|
| Sexual abuse of a minor (SAM) | 308 | 4 arrests |
| Sexual assault (SA) | 160 | 5 |
| **Total** | **468** | |

## Figure 48. Number of Months to Recidivism

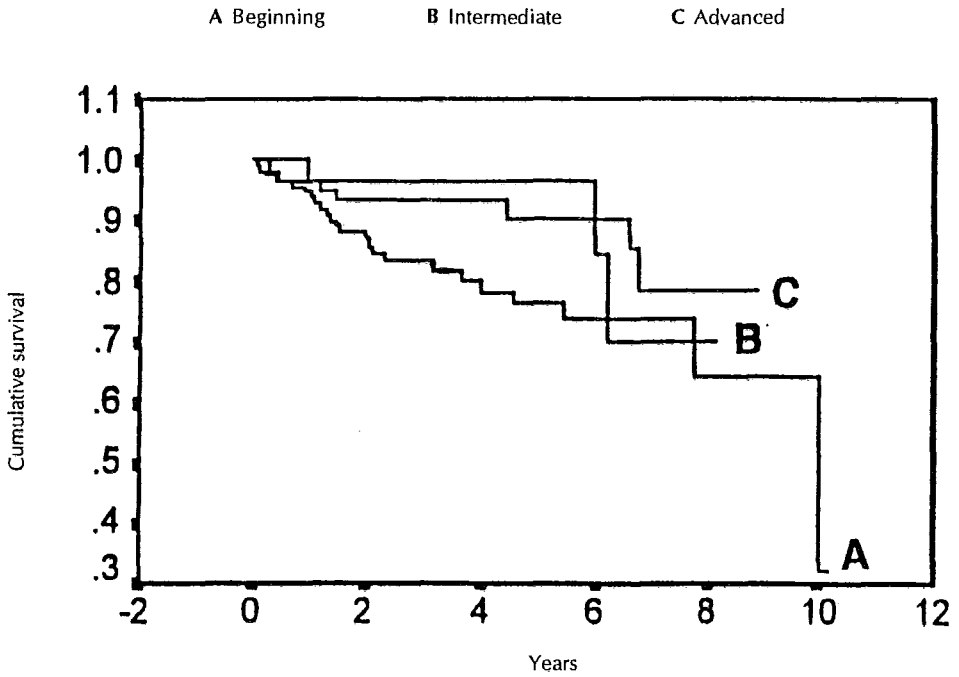



For those who had a reoffense, the mean reoffense time was shorter for those initially convicted of sexual assault. Therefore sexual assault (SA) offenders had slightly more rearrests and reoffended sooner.

### Table 48. Number of Months to Recidivism

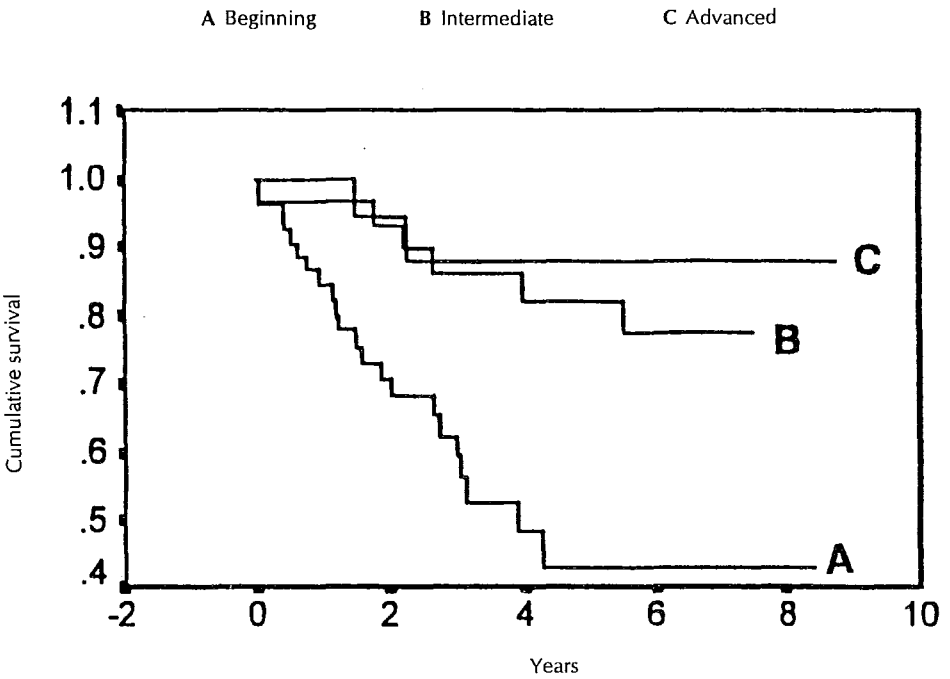
| | Sexual abuse of a minor | | Sexual assault | |
|---|---|---|---|---|
| | N | mean months | N | mean months |
| First offense | 259 | 31 months | 135 | 22 months |
| Most serious offense | 259 | 31 | 135 | 30 |
| First sex offense | 259 | 40 | 135 | 42 |
| Most serious sex offense | 259 | 49 | 135 | 39 |
| First non-sex offense | 259 | 49 | 135 | 22 |
| Most serious non-sex offense | 259 | 30 | 135 | 28 |

**Figure 49. Survival to First Arrest: Sexual Abuse of Minor (SAM) Offenders by Treatment Level**




Survival data was analyzed for SAM and SA offenders to determine if stage achieved was related to survival for these two groups. The data for SAM offenders is in the direction predicted, but the differences are small.

**Figure 50. Survival to First Arrest: Sexual Assault (SA) Offenders by Treatment Level**




Stage achieved appears to be especially important to SA offenders. Achievement of intermediate or advanced stage is related to survival as measured by first arrest. The difference is statistically significant.

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# VI. Conclusions and Recommendations

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## VI. Conclusions and Recommendations

There are a number of important findings that have emerged from the present research project. Several of these will be the focus of the concluding remarks, including:

- The majority of the sex offenders in the treatment group assaulted children.
- The Sexual Assault (SA) offenders do as well as the Sexual Abuse of Minor (SAM) offenders, both in terms of how long they stay in treatment and how far they advance through the phases of the program.
- There was a higher percentage of Alaska Native offenders in the treatment group than would be expected in comparison with the population.
- Alaska Native offenders tended to leave the program earlier than White offenders. The Alaska Native offenders who leave the program early are older, more educated, and have a history of both alcohol and drug abuse.
- Two-thirds (67.7%) of the offenders in the treatment group had a history of substance abuse. The incidence of substance abuse was even higher among Alaska Native offenders. For all offenders, those who had no history of substance abuse tended to advance further in program. Those with a history of both alcohol and drug abuse tended to leave in the earlier phases of the program.
- Almost half (45.3 %) of the offenders in the treatment group were in program for a year or less. The average length of stay was 17 months. Almost 60% were discharged during or just after completion of the Beginning phase.
- Longer sentences tended to relate to further advancement in treatment.
- Treatment at any level improves survival in the community without re-offense. The further offenders advanced in treatment, the more benefit is derived, with those completed all stages having no re-offenses. This is particularly true for SA offenders, who tend to re-offend more quickly and at a higher frequency.
- For some offenders (SAM), there was not much difference in re-offense rate between those who reached intermediate phase and those who reached advanced stage in the program.

This research demonstrates that treatment can work, at least for some offenders. It works by reducing the incidence of sexual re-offense (as measured by new arrest data) or by prolonging the time until re-offense. Either of these results reduces the number of victims in the community. When treatment does not work for certain offenders this information is equally important. Sexual assault is not a disease which can be cured. It is an aggressive behavior which results from the convergence of a complex number of factors. It can however be contained and managed. Offenders who are amenable to treatment and willing to actively participate learn to recognize precursors to relapse and self manage their high risk behavior. Those who are not amenable and/or not willing to participate in treatment must be controlled by external measures. It is important to recognize that offenders differ along a continuum of risk. Identifying the extent of the risk and the conditions under which an offender is likely to relapse allows the offender and others to manage the risk more effectively. Approaches which have focused on relapse prevention have been effective in reducing risk to the community. Treatment strategies and management strategies go hand-in-glove.

The research findings suggest that the HMCC program has been able to identify not only offenders who are amenable to treatment by virtue of their basic faculties, but also offenders who are amenable to incorporating the principles of treatment, and thereby attaining a higher level of internal management. The Intermediate and Advanced stage of treatment appear to identify these later individuals. Not all offenders are capable of attaining this stage of treatment. However, any level of treatment appeared to yield significant benefits. During on-site program reviews over the last several years, one of the present authors asked offenders to rate the effectiveness and helpfulness of the HMCC program. Even offenders who left program (ATA), or who were removed, acknowledged that they had derived benefit from the time they spent in treatment. The present research data seems to support this. The findings seem to suggest that offenders should be encouraged to participate in treatment until they have derived the maximum benefit that they are capable of achieving.

It is possible, through continued research effort, to determine a constellation of factors which would be predictive of treatment success at different levels. DOC should attempt to identify such predictors through continued research efforts. This would assist in developing a more objective definition of "maximum treatment benefit." We cannot expect advanced treatment stage from all offenders, but it would be helpful to have a more objective criteria for determining when offenders had derived, what is for them, the maximum benefit. External supervision could then be altered according to the level of risk. This would partly be determined by treatment stage and partly by other variables such as seriousness of offense and other factors. Such an approach would increase the efficiency of treatment. It would also provide a more objective basis for making decisions about furlough and parole, thereby enhancing community safety.

Some of the data suggests that there is not much difference between Intermediate and Advanced stage offenders with respect to recidivism. This suggests that these two phases might be combined to shorten treatment for some offenders. This would decrease the cost of treatment and increase the number of offenders in treatment. DOC needs to explore this possibility further.

Many of the findings suggest that Alaska Native offenders leave treatment early. The reasons for this are not entirely clear. Overall, Alaska Native offenders are younger, tend to abuse substances more than their White counterparts, and tend to have less formal education. Each of these factors have been shown to contribute to the lack of advancement in treatment in the present study. However, other analysis suggested that it was the older, more highly educated Alaska Natives that were leaving program early. Severe substance abuse also appeared to be related to early discharge. Further research will be needed to identify and correct the specific problem(s) which lead to early withdrawal from program. This is extremely important since Native offenders made up 38 percent of the SOTP population.

During the past two years, the HMCC program has undertaken a number of steps to improve services to Native offenders. Changes have included a pretreatment orientation for Natives, mentoring by more advanced-phase Alaska Natives, monthly Alaska Native Planning and Support Group, staff training and curriculum development to incorporate Alaska Native values and practices, collateral contacts with families, initiation of a "week of reflection" which encourages offenders to reflect about their desire to quit program and other changes to try to make programming more relevant and appropriate to Native offenders. Additionally, efforts are currently underway to further augment Pretreatment and beginning treatment by incorporating native healing and spiritual practices. The data included in this study only includes participants through August 1995. Given these changes, it will need to be determined if the same pattern emerges, or if there is a change, once the current year's data is analyzed.

With its focus on the recidivism of the sex offender population, the present study is the first of its type in Alaska. The database has value for the continuing study of sexual offending in Alaska. To be optimally useful, however, the database must be established at the LCCC Pretreatment Program and in the community programs so that the effectiveness of treatment at these sites can be assessed. This is a major undertaking, however, involving manpower, equipment and funding.

At HMCC, the consistent entry of demographic, psychological testing, and clinical information into the database assists in ongoing assessment, supervision, treatment, management, report writing, and program evaluation, as well as research and recidivism studies. Similar efforts at LCCC and in the community should increase efficiency, both in treatment and in program evaluation at these sites. Throughout the process of analyzing the data, there have been indications of data elements that were needed, but which are not currently being collected. These will be added to the database as it evolves.

The database itself has value as a model for other data collection systems which may be developed in the future. The effectiveness of programs in areas other than sexual offending can be improved by the on-going collection of data. Such data systems provide on-going feedback which improve efficiency of programming.

## Cost-Benefit Analysis

There are many reasons for funding effective sex offender treatment which reduces crime and the number of victims, including some practical reasons. Several studies have demonstrated how effective sex offender treatment saves taxpayer dollars.

Prentky and Burgess (1990) outline the costs of treating an offender and the relative risk of re-offense compared to just the cost of incarcerating an offender and their probability of re-offense. The authors sought to address the question of whether treatment of sex offenders was cost-effective by looking at the cost of treatment of 129 child molesters treated at the state hospital at Bridgewater, Massachusetts and comparing their re-offense rates with a control group of untreated child molesters from Canada. In both cases they looked at charges on new sex offenses in a five year follow-up, finding that 25% of the treated child molesters were charged with a new sex offense, while 40% of the untreated child molesters were charged with a new sex offense. Prentky and Burgess computed the cost when there was a new, detected sex crime against one victim at $183,333, which included the costs of investigation, arrest, prosecution and incarceration for an average of seven years and treatment and care for one victim. The cost for treating a sex offender for five years was computed at $118,146.

A similar analysis was conducted by McGrath (1994), as noted in Steele, 1995. McGrath calculated the cost benefits of Vermont's community-based sex offender treatment program and found that the cost to the State to provide out-patient treatment is $103,800. If recidivism is reduced by only 1%, the State saves $35,000 over the cost of the program. If recidivism is reduced by 8%, there is a $1 million savings to the state.

In another analysis of the cost factors involved in treatment, the costs of incarceration with treatment were compared to the costs of incarceration without treatment in the same prison, at the Minnesota Sex Offender Program (Steele, 1995). The cost of treatment of one offender was calculated at $2,473.60, which was compared with Prentky and Burgess' calculation that a new offense costs $183,333. The author concludes that if treatment resulted in even one less sex offense, then the State would be able to treat an additional 74 sex offenders. She further points out that the recent trend toward mandatory life sentences for three violent offenses will result in a cost of incarceration of over $1 million, not including any medical treatment for serious illness or inflation.

If one assumes that there will frequently be more than one victim, both pre- and post-imprisonment, then it follows that the cost of incarcerating sex offenders without treatment will be higher than that of treating them. Following this logic, the studies noted (Burgess and Prentky, 1990; McGrath, 1994; Steele, 1995) appear to demonstrate that treating sex offenders appears more cost-effective than incarceration without treatment. Similar figures for Alaska were not available to the authors of this report, however, it could be assumed that there would be a similar cost difference if the relevant information was compiled. Obtaining this type of information for Alaska, however, is a research project in its own right, involving both time and funds.

## Recommendations

The nature of sex offenders necessitates close teamwork and cooperation. Sex offenders are adept at finding the weak link in the system and using it to their advantage. All parts of the system must work as a team for treatment to be successful. Based on the results of this research, it is recommended that the Department of Corrections develop a plan for addressing the system-wide issues involved in the treatment of sex offenders in its custody, both within the correctional institutions and on probation/parole supervision. At a minimum, the following should be addressed:

- Determine changes in service delivery which may be needed in order to address the differences between Sexual Assault (SA) and Sex Abuse of a Minor (SAM) offenders.
- Assess the needs of Alaska Native sex offenders and determine what effect changes implemented within the past year have had on this population.
- Develop a plan for future research on the factors which are predictive of treatment success.
- Identify system gaps and develop a plan for future development of both institutional and community programs for sex offender treatment and management.

- Develop standards for external monitoring of sex offenders who are determined to be unamenable to treatment.
- Develop recommendations for changes needed in other branches of government, including possible statutory changes.
- Identify potential funding for further research and program development.

# VII. References

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